NC DHHS Business Plan

Prepared for the

NC DHHS Division of Information Resource Management

in response to
S.B. 622-10.1(a)

prepared by
The Office of Policy and Planning
December 1, 2006

Mission

The mission of the North Carolina Department of Health and Human Services is to provide efficient services that enhance the quality of life of North Carolina individuals and families so that they have opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence.

Vision

By 2008, the North Carolina Department of Health and Human Services will be a national leader in improving the health, safety, and independence of its residents.

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Part I:

Introduction

Background of the NC DHHS Business Plan

Information technology management in North Carolina has been in a state of change for several years. A newly created NC Information Technology Services (NC ITS), headed by NC's first State Chief Information Officer, reporting directly to the governor, is leading the state toward consolidated IT decision making, funding and control. In order for NC ITS to perform its coordinating and control function, the legislature enacted Senate Bill 622-10.1 (a) (see Appendix 1) which requires the North Carolina Department of Health and Human Services to develop an IT plan that will lead to the development of an "enterprise-wide" approach to future IT design and utilization. The statute required the IT plan to be based on a broader business plan that identifies business requirements within NC DHHS for the next three to five years. The purpose of the business plan is to aid NC DHHS's Division of Information Resource Management (DIRM) in development of an IT plan "tied directly to business requirements", and subsequently, the enterprise architecture plan for the department. NC DHHS' Office of Policy and Planning (OPP) assumed the responsibility of developing the business plan and worked closely with DIRM over the past year to complete this legislative requirement.

Most government planning efforts generally focus on programs and services and whether they adequately provide for the improved wellbeing, safety and health of the public, as well as where those programs and services should be organized within state government. However, planning around *what* we do with regard to programs and services is often done outside of NC DHHS—either by advocates or providers or specific populations that push for changes in federal or state requirements. Since the business plan was to identify business requirements, OPP focused on the operational aspects of DHHS rather than the programmatic aspects. In other words, this business plan focuses on *how* we do what we do rather than *what* we do.

Just as in programmatic aspects, *how* NC DHHS conducts its business is rarely an entirely internal decision making process. Everything is subject to multiple layers of oversight—from changing an IT system, to signing a new lease or contract, to determining availability and allocation of financial resources, to most personnel decisions. Like other government entities, NC DHHS is delegated enormous responsibility, is expected to satisfy often competing stakeholders, and is not in total control of its future. While oversight is essential to protect tax dollars and to guarantee the safety and health of the public, it is time to take a close look at operations and determine steps to improve *how* we operate when oversight and outside influences limit authority and slow response times. The requirements in Senate Bill 622.10-1(a) provided the impetus for just such a study at NC DHHS. Thus, three goals were established for this business planning process:

- Meet the legislative requirements of SB 622-10.1(a) so that DIRM would have clear direction for the IT plan and the Enterprise Architecture plan
- Identify the fundamental high level NC DHHS business drivers for the next three to five years
- Gather broad information that will inform future operational improvements across the NC DHHS spectrum.

The Planning Process

As in all daunting tasks, the first question was where to start. OPP and the Enterprise Architecture (EA) team at DIRM developed survey instruments to gather information in a standardized manner. Additionally, they agreed to meet on a regular basis, to utilize a standardized reporting format as a means of keeping each other apprised of project status, and to follow an agreed upon time line for the project. It

was determined that the DHHS Program Management Database (PMD) would be used by the EA team to identify all programs and services in the department. Those programs and services were individually canvassed by the EA team to gain an understanding of the business objectives of those programs and services. In the process, the EA team developed an exhaustive inventory of the department's IT systems and a perspective of the business needs they support. OPP and the EA team kept the focus on the business needs rather than any specific IT needs.

OPP developed an interactive Business Plan Questionnaire (see Appendix 2) which NC DHHS divisions and offices used to provide consistent information for review. The information from those questionnaires, along with information from individual follow-up meetings with all those agencies and other information provided was used for two purposes. The first was to develop individual agency profiles so that individual missions, goals and needs of the various agencies would receive the attention they deserve. Executive level staff also were interviewed, and their input is summarized in the Executive Profile. Only those functional areas composed of one or two people and which do not utilize specific IT systems, are not included in this final document although an attempt was made to gather information from all separate entities.

The second purpose of the questionnaire was to accumulate information that would inform the broader NC DHHS perspective. Operational issues and demographic trends identified in the business plan questionnaire and the follow-up discussions were evaluated and summarized by OPP to determine over-arching issues and challenges facing the department. This information is presented in Appendices 3 and 4. Additionally, OPP used this information to develop a Strengths, Weaknesses Opportunities and Threats (SWOT) analysis for the department; it is presented in Appendix 5.

During the information gathering phase, OPP and the DIRM EA team also studied examples of other public and private sector business plan outlines as well as IT plans and agency strategic plans. A traditional operational approach was selected as the means for presenting the results of the business planning process. In addition, it was determined that in order to provide DIRM the guidance needed to develop the IT and EA plans, the business plan needed to highlight the overarching business drivers that are fundamental to DHHS future operations. After lengthy discussions and gleaning of information provided, review of interview notes and the SWOT analysis, five overarching drivers were developed. These drivers, along with some approaches to manifesting them, are presented immediately following this Introduction.

The Business Plan Overview

As the reader can see, a significant amount of information was gathered during this process, and this document is quite lengthy. But, to facilitate review by multiple potential audiences, and to allow for ease of use of all the information gathered, the plan is organized in the following manner:

- ⇒ Part I —Introduction
- ⇒ Part II—The Business Plan. This section presents the essence of the overall department business plan. It is presented according to the following business functions:
  - Management Vision and Control
  - Information Technology
  - Workforce
  - Program and Service Delivery
  - Budget and Finance
  - Communications
  - Buildings and Facilities

⇒ Part III—Divisions and Offices Profiles. This section contains profiles on individual programmatic and support divisions and offices within NC DHHS. These profiles offer an excellent view of the special circumstances of the specific divisions and provide an opportunity to reflect the unique responsibilities of those entities

⇒ Part IV—Appendices. This section contains demographic information and operational issues gathered during this process.

Planning in a Changing Environment

Like other agencies of state government, NC DHHS is impacted by multiple and significant demographic trends. (See Appendix 4 for a summary of demographic trends.) North Carolina's population is growing rapidly and is expected to increase 55% by 2030. In the 65+ age category, the increase will be over 1.2 million, or about 125%. The state also is becoming more multi-lingual and multi-cultural as evidenced by a 450% increase in the foreign born population since 1990. In the same period, the illegal immigrant population in North Carolina is estimated to have grown nearly 1,600% (from 25,000 to 395,000), among the highest percentage increases in the nation. This larger, aging and more diverse population will increasingly stress resources of a human services department chartered to provide programs and services to all who are in need. It is clear that these changing demographics require greater fluidity and faster implementation once change is identified.

NC DHHS has defined success through a Mission and Vision that emphasize "… opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence." To recognize these objectives, in a world where human and financial resources will always be in short supply, DHHS must achieve operational excellence through adherence to the drivers identified in this very timely business planning process.

In many cases, these factors are within the Department's control: better operational management, including adoption of benchmarks and best practices; adapting to cultural change that will enable better information sharing with a focus on performance management; and utilizing management tools provided through improved information technology and data management.

Other important factors are not in the Department's direct control: legislative funding decisions; state-mandated policies, procedures and oversight; and federal/state mandates that may or may not include associated resources. Even though this business plan has identified factors that impact our ability to achieve operational excellence and that will direct our actions, it must be recognized that DHHS' success is contingent upon receiving the support and cooperation of external entities.

In closing, it is important to recognize that a business plan is a fluid document. It provides a road map to the future. But the challenge is great, and the road map must be referred to often. It must frequently be reviewed in light of internal and external limitations, but the overarching drivers that follow can guide future actions and provide the basis for future decision making for the Department of Health and Human Services and its individual divisions and offices.

Business Drivers

- ✓ **NC DHHS will employ an enterprise-wide approach in the design and delivery of programs and services for the ultimate benefit of North Carolina residents by:**
  - Implementing evidence based practices with an emphasis on prevention
  - Providing seamless access to an array of services that are locally available, client and family centric and outcome oriented
  - Utilizing program funds in a flexible manner that is responsive to changing needs, maximizes outcomes and meets state and federal requirements
  - Ensuring access to services by people with disabilities and those who may have special needs relating to language, culture, or ethnicity.

- ✓ **NC DHHS will sustain a culture of continuous improvement by:**
  - Identifying and implementing best practices and measuring for results
  - Empowering decision makers
  - Sustaining a high performance workforce
  - Providing tools to enable decision making

- ✓ **NC DHHS business needs will drive operational decisions and resource allocation by:**
  - Maximizing the use of human, technological and financial resources to enable business activities through coordinated planning processes

- ✓ **NC DHHS will leverage resources to achieve operational efficiencies by:**
  - Streamlining business processes
  - Implementing process improvement prior to automation
  - Enhancing access and transparency of information
  - Identifying opportunities for cost avoidance, savings and recovery
  - Ensuring the continuity, reliability and security of data and support systems

- ✓ **NC DHHS will enhance internal and external communications and marketing efforts to continue our focus on customer service by:**
  - Analyzing complaints and call center data to shorten response times and improve programs and services
  - Applying technology and best business practices to improve the ways in which we collect, share, analyze and use information from stakeholders and consumers
  - Targeting messages to the public about NC DHHS programs and services and their impact on the quality of life in North Carolina
  - Supporting the tools, processes, and resources necessary to inform and connect a large, diverse and geographically dispersed workforce

Part II:

The Business Plan

Summary information provided in this section is based on agency responses to the NC DHHS business plan questionnaires, the follow-up interviews and additional information when provided. (See the attached appendices for individual agency profiles, demographic summary information, Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis, and other supporting documentation.)

As stated in the Introduction, the business plan is presented according to the following business functional areas:

- ⇒ Management Vision and Control
- ⇒ Information Technology
- ⇒ Workforce
- ⇒ Program and Service Delivery
- ⇒ Budget and Finance
- ⇒ Communications
- ⇒ Buildings and Facilities

Management Vision and Control

As defined in G.S. 143 B-10, the Secretary of NC DHHS is responsible for the functions of management and administration which include: planning, organizing, staffing, coordinating, evaluating, reporting and budgeting. That same level of responsibility is shared with and delegated to the directors of the agencies of the department.

Management **is generally thought of as unified leadership of an organization that includes controlling policy, business and budgetary activities, products and/or programs, internal operational controls, and intelligent foresight so that decisions are centralized, implemented and beneficial to the success of the organization. In other words, management vision and control must include not only the responsibility but also the authority to allocate all available resources in such a manner to achieve the mission and goals of the organization.**

Current Environment

Management of NC DHHS is a challenge not because of a lack of management vision or dedicated leadership; rather the challenge is created by the delegation of enormous responsibility without the independent authority to control the direction and management of the organization. Furthermore, there are a myriad of state and federal laws, rules and regulations that control the majority of NC DHHS endeavors. Most agree that NC DHHS has strong leadership in its Secretary and that agency directors are programmatically very committed; yet strong leadership is frustrated by the system in which it must operate. Instead of being nimble and promptly responsive to ever-changing population needs and programmatic mandates, NC DHHS operates in a system characterized by:

- "siloed" funding streams that limit flexibility;
- multiple layers of review which are time consuming, create disjointed decision making and may result in duplicative requests for information;
- a governmental tendency toward incremental change which may create less than desired outcomes in favor of modest modifications;
- growth in demand for services without a corresponding growth in resources;
- inflexible human resource rules and regulations that stymie management authority, productivity and morale;
- a patchwork of legacy systems that do not communicate or facilitate data sharing;
- a lack of systems to effectively support business processes;
- an historic emphasis on transactions and activities rather than outcomes and performance paired with a wariness toward process improvement analyses;

- a workforce that is spread over the entire state in more than 900 mostly outmoded buildings, 200 leased locations, and hundreds of private homes with LANs, telephone systems, calendar, and email software that are often incompatible, and
- external influences that demand immediate action to the extent that internal planning and control is difficult to achieve.

All of these factors contribute to an environment of frustration and a preference for avoiding the controversy and hassles that accompany change. A work environment with multiple layers of oversight and second guessing produces managers who learn to "make do" by working around system problems rather than solving them.

TO accomplish several key projects, such as strengthening fraud and abuse efforts, and ensure adequate financial monitoring, the Division of Medical Assistance (DMA) requested an additional forty three permanent, full-time employees. As part of the justification for the positions, it was demonstrated that Medicaid recoupments alone, through increased fraud and abuse efforts, would more than pay for the positions. After consideration of all internal requests, DHHS executive leadership approved the request and included it in its expansion budget. Subsequently, the Office of Management & Budget denied the request in total because they did not believe the positions were needed.

Key Operational Issues

Management is done by people using skills, information and tools to conduct analysis and develop recommended courses of action to maximize utilization of scarce resources to achieve mission and goals. Yet a review of the ten most frequently mentioned operational issues (see PAGE 137) indicates that both programmatic and support agencies within NC DHHS do not feel as though they control the necessary resources to provide maximum performance. Out of the top ten issues the operational agencies list four as workforce related, two as process related and one as IT related. The programmatic agencies list three as workforce, three as IT and one as process improvement.

Over the last several years, NC DHHS senior management has promoted several performance based management initiatives—performance based contracts, creation of centers of excellence, development of a program management database, instituted a program review process, supported such system-wide program performance improvements as NCFast, placed a greater emphasis on customer service, and other efforts to improve the way we manage ourselves and our work. These initiatives are producing results; however, there are numerous operational issues that continue to hinder NC DHHS management direction and control.

Two of these issues are of pre-eminent importance—our workforce and our need to expand and improve IT resources. Like other governmental agencies, NC DHHS is facing a looming management brain drain that will greatly impact the future leadership of NC DHHS. Senior managers in most of our agencies are nearing retirement and wondering how and where to identify future leaders (see also the section on Workforce, p. 24). On the Horizon, published by the Retirement System Division of the NC Department of State Treasurer, spring 2005, stated that "North Carolina is staring at a retirement curve that's projected to climb steadily over the next 17 years, as more baby boomers leave work and retire. Over the 17-year period, retirements are expected to increase 141%." Applying these numbers to a department as large and critical as NC DHHS paints a dire management future. Somehow we must eliminate current inhibitions on attracting, retaining, training, and rewarding staff based on performance rather than longevity and programmatic expertise. If NC DHHS is not able to take immediate steps in this direction, how can future management vision and control be guaranteed?

Additionally, the department collects enormous amounts of information in autonomously designed and funded databases which cannot communicate with each other, thus creating information silos which impede department-wide analysis. These silos are created by both the perception and the reality of restrictive programmatic funding that limits access to information and that earmarks funds for particular purposes. Add to these the layered and time consuming review by IT, budget, contracting and other entities—internally and externally—and our reliance on legacy systems that date as far back as the 1970's, and it becomes nearly impossible for department management to be nimble, quickly responsive and creative in its decision making. Updating IT needs in a timely and thorough manner would provide a new level of interoperability that will improve communications, reduce silos, and allow broader analysis and utilization of resources to better manage our day-to-day operations and to better serve the people of North Carolina.

Achieving Operational Excellence in Management Vision and Control

To address these operational issues and to achieve operational excellence, NC DHHS will continue several performance management initiatives currently underway to the extent that human resources and funding are available.

The performance management database (PMD) has become widely accepted as the source for information on programs and services throughout the department and has helped provide the performance foundation mechanism for the department. NC DHHS is one of the leading departments in the state with an existing and widely accessible database of such information. Utilization of the system to date has resulted in a broader awareness of programs available to residents, the development of a common language around outcomes and performance expectations, and facilitated review of program performance.

In addition to proceeding with recent system design improvements to the PMD, NC DHHS is moving forward with plans to combine the contracts database and the subrecipient monitoring database with the PMD to develop the first fully integrated management tool around programs. This will allow managers at all levels of the department to fully understand the relationship between program mission and goals, how services are designed to support those programs, and the connection between contracts with subrecipients who deliver those services and how effectively they are being monitored for outcomes.

Additionally, the PMD is being used for peer review of programs which offers opportunities for greater collaboration between similar programmatic agencies within the department and broader oversight of program and service performance than ever before. It is also being used to support block grant reports and the expansion budget process. The recent OSBM decision to implement results based budgeting is another opportunity to further utilize the PMD as a management reporting and decision-making tool.

To address the looming workforce challenges, the department has created a small work group to address succession planning. One of the recommendations from the group was the creation of ***LeadershipDHHS.*** Now starting its second year, it is generating a lot of enthusiasm throughout the department and will shortly require expansion. While this is proving to be a successful way of identifying potential future leaders who are interested in a long term management career in human services, if the state personnel system does not allow for proper recognition, reward for performance, modernized job descriptions to fit today's needs, and adjust salaries to market rates, ***LeadershipDHHS*** will fall short of its goal to foster future management.

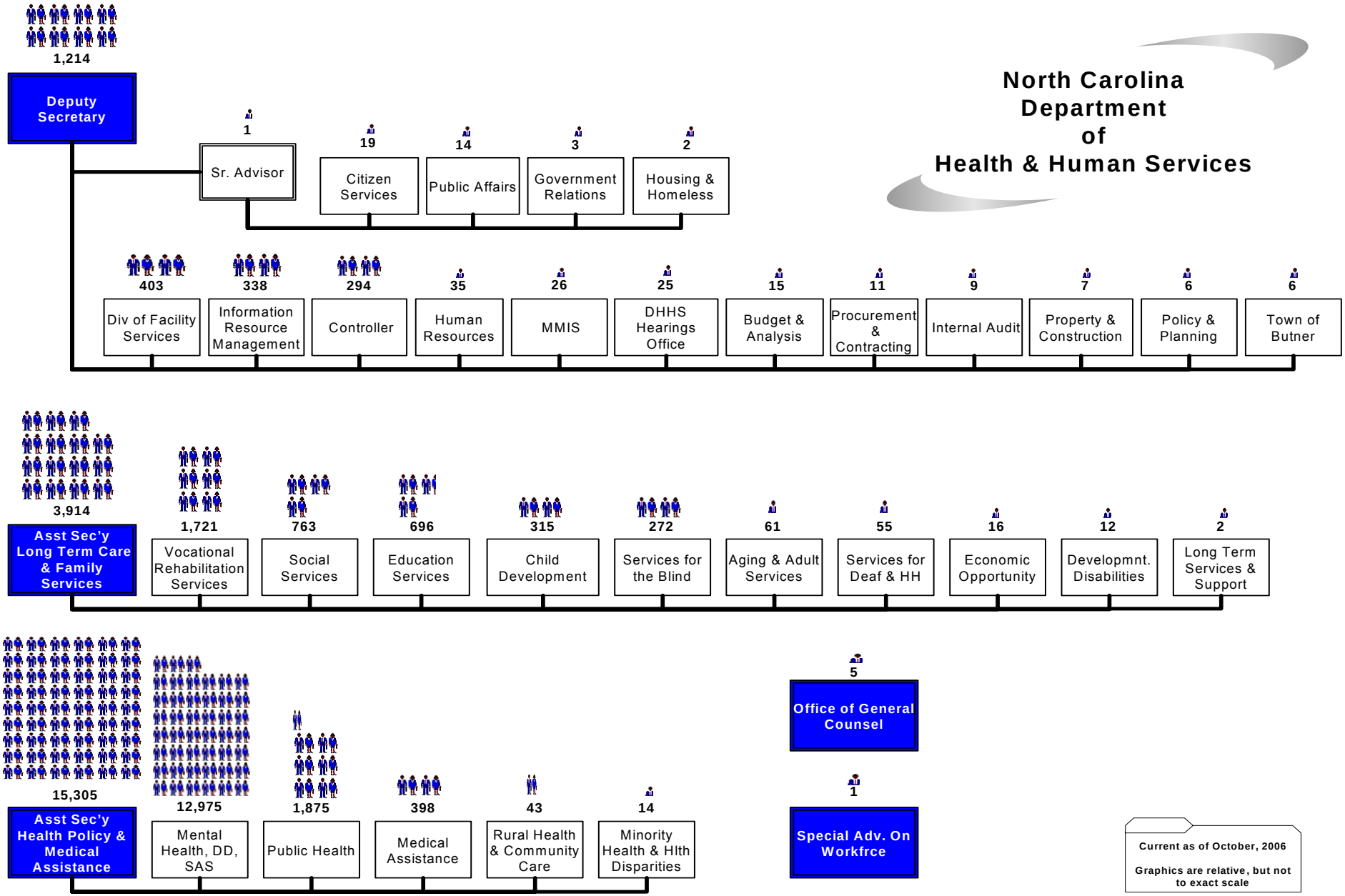
A third way NC DHHS is addressing its management vision is through greater use of process improvements. The department has experienced success with efforts to make process improvements,

most notably the consolidation of the criminal record check (CRC) function into one central unit which resulted in the elimination of backlogs for CRC requests in the child care arena. This same kind of analysis is underway in other areas also. As acceptance of the value of process analysis grows, there will be many opportunities for automating manual processes. As these are identified, it is especially important to conduct process improvement studies prior to automation of the many manual processes throughout the department and to design these solutions in an enterprise manner so as to maximize cost and utilization.

NC DHHS is currently studying the way it manages its public records. Millions of paper documents consume thousands of square feet of storage space and yet frequently the "right" document cannot be found when needed. Electronic document management systems that provide scanning, archiving and search capability across the department are immediate requirements. Utilizing such capability will facilitate information sharing, provide additional workspace, secure vital records, eliminate a lot of paper handling and provide greater efficiency.

In addition to these specific efforts, current NC DHHS executive leadership has established a management culture that encourages cost containment, is supportive of setting performance expectations, strives to offer services that are evidence based and available in the community, places emphasis on keeping a consumer focus in program design and delivery, and has a growing awareness of the value of process improvements and better collaboration. Being successful at these things is predicated on management authority to maximize utilization of scarce resources (primarily human resources and information technology) to achieve mission and goals. This can only happen if other governmental oversight and systems support management, add value, and enhance responsiveness.

North Carolina Department of Health & Human Services



Information Technology

Information Technology refers to the management of all electronic information resources for the entire organization, whether managed centrally or under the control of individual divisions and offices. This includes hardware, software, networking, and telecommunications technology utilized to facilitate the sharing of information, automation of business processes, management and analysis of business data, and support of general work functions to support business operations and achieve the organization's objectives.

The Current Environment

NC DHHS is one of the largest departments in NC state government with one of the largest IT budgets. The department has offices and facilities spread across the state. The number of programs and services administered through the department is in the hundreds, and at some point every person in the state is directly impacted by them. The work of the department is funded by many different sources, including numerous federal grants, state appropriations and private grants. Each of the different funding sources comes with its own set of compliance requirements, which makes collaborating around common initiatives difficult. The nature of health and human services work is complicated and diverse; consequently, identifying stable, repeatable processes is a challenge. Having many different funding streams supporting numerous diverse programs and services fosters silos in the organization. The silo effect is further exacerbated by the fact that historically the IT function was completely decentralized and the divisions of the department as it exists now have not always been in the same department. All of these things make for an extremely challenging environment for effectively managing information resources.

Nonetheless, the department has many strengths in the area of IT. Most notable is the elevated recognition that IT is critical to its business functions. The department also has a wealth of data in many systems that support its programs and services and strong automated federal reporting capabilities. Also, as a result of the department's depth of knowledge about the needs of people with disabilities, IT is very supportive of accessibility requirements. Finally, though there are many legacy systems, creative problem solving has extended the life of these systems beyond expected life cycles.

The Division of Information Resource Management (DIRM) has the primary responsibility of providing leadership in the use of information technology. While some divisions rely heavily on DIRM to provide IT support, others have traditionally operated independently. Multiple efforts are underway to enhance IT in the department; for example:

- There is a growing emphasis to align essential IT functions throughout NC DHHS. Significant details have been learned about departmental IT activities as a result of collecting information for this business plan. Continual advancements in the department's IT responsibilities over the next few years are expected.

- DIRM has relied heavily on contract staff to fill voids on new technology. They are currently in the process of replacing a significant portion of its consultant workforce with state positions. Initial training dollars have been identified to assist in continuing education for the current staff. This will require sufficient funding sources allocated on an annual basis for the training of employees in emerging and applied technologies. This approach will allow DIRM to provide the technology leadership needed to advance NC DHHS in the coming years.

- Senate Bill 991 has stepped up the State's efforts to better plan, budget, and manage IT resources. This process has been a work in progress. Measures are now in place to regulate project management practices and authorizations. Internal NC DHHS procedures have been developed and implemented to support the Senate Bill 991 requirements.

While these improvements to the management of IT in the department are very positive, there will continue to be additional opportunities for DIRM to redefine its role and restructure its operations to better support departmental IT efforts.

One example of inefficiency due to lack of automation is the license renewal process at DFS. Currently, the process is labor intensive and takes months to complete. A thick packet containing information printed from the Master Facilities File (MFF) is mailed across the state to thousands of facilities which are asked to verify that the information is correct. These forms are returned to DFS where a temporary employee hired for roughly three months enters changed or new data into the system. Final documents are then printed and licenses mailed out. This whole process could be tremendously simplified and cost reduced by enabling the licensure information to be updated via secure internet access – rather standardized procedures for thousands of web site applications everywhere. DFS has tried numerous times to automate this process. Earlier, funding was not made available and more recently, the MFF function was added to the NCLeads project, which is now pending a re-bid process that will cause further delay.

Key Operational Issues

A total of 17 issues related to information technology were reported in the interviews and analysis. These can be seen in the Operational Issues Matrix in Appendix 3 and can be summed up into four areas: Opportunities to Enable Business, Need for an Enterprise Approach, Legacy Systems, and Accessibility.

Opportunities to Enable Business
Several of the issues identified reveal specific opportunities where IT that is standard in doing business can greatly enhance the business operations of the department. These issues are a need for better automation of manual processes, a need for ad hoc management analysis of data for decision support, and a need for electronic document management.

The most reported operational issue related to Information Technology, and the second most reported issue in all functional areas, is a need for more automation of manual processes. Throughout the department there are numerous business processes that are very manual and paper driven. These include getting signatures for official documents when approvers are in multiple physical locations, receiving and paying invoices, and collecting data from external entities. There is significant opportunity to improve these and other situations through the effective application of IT in conjunction with process re-engineering.

Related to better automation of manual processes is a strong desire for electronic document management. One reason is a need to free space that is currently occupied by rows of filing cabinets and stacks of boxes. Another reason is the need to access important documents quickly and easily, regardless of physical location. A third reason is the need to more easily determine what documentation the department has. Finally, electronic documents would allow not only concurrent approvals and conserve staff time spent driving documents around for signatures; it would also decrease overall processing time.

A final enabling business issue is a need to access data for decision support and management analysis. In spite of the wealth of data residing in many systems, frequently managers cannot easily access that data to do ad hoc analysis. Usually, if a manager wants to get answers to a question from data, s/he has to involve IT staff which greatly delays getting answers and prevents IT personnel from working on other tasks. Powerful tools exist that put managers in the driver's seat when trying to access and analyze their data, as is the case of the department's Client Services Data Warehouse (CSDW); however, its use could be expanded, particularly for management analysis. An opportunity exists for educating leadership about this tool and incorporating more data in it to support things like evidence based decision making and evaluation of outcomes.

Need for an Enterprise Approach to Information Technology

Throughout NC DHHS, there are existing and planned systems that provide much value to the programs and services they support. However, it is not uncommon for functionality, such as patient billing, case management, and various registries, to be duplicated in multiple systems. It is also not uncommon for programs to be left out of IT systems that could provide valuable functionality to their services. Smaller divisions see potential benefit from the functionality in applications being developed like NC FAST, but had difficulty getting their interests represented in such a system. For this reason, a process needs to be in place to ensure that when the department invests in new systems or enhancements, a holistic view of its applications to the department is considered.

There is also a need for a more unified and consistent approach to managing the basic technology infrastructure. Some agencies have current computers that are being managed and kept up to date; others have to make do with cast-offs from other state departments. Some office locations are supported by a help desk and technicians using standards for ticket tracking and issue resolution; others are not. Numerous reasons exist for this, including different funding streams and a history where the operation of the divisions was more separate. However, such an approach is expensive and very difficult to manage.

A frequently expressed need was for enhanced sharing of data, yet two barriers were identified: lack of a technical link between related data or systems and a reluctance to share data. For example, all counties do not use the same system to track Child Protective Services cases. When individuals move across county lines, social workers who encounter the family in the new county have no idea that there was a Child Protective Services case in the other county. In this example, the parties involved are willing to share the data, but the technical links to do so are not in place.

The reluctance to share data seems to primarily result from fear of violating HIPAA or other security regulations and confusion over data "ownership." While HIPAA and other security guidelines need to be taken seriously, fear of violating the guidelines sometimes causes unnecessary restrictions, such as the preventing the analysis of de-identified data. To address this barrier, clear guidelines need to be established in the department around data ownership, along with a process of arbitration when barriers are put up.

While most agree that an enterprise approach to managing and delivering IT services is ideal, smaller divisions were concerned that their specific needs would be lost in the discussion. Others felt that expanding systems to meet smaller needs would drive up the cost and lengthen the implementation of

such systems. Still others felt that guidelines coming from differing sources (e.g., departmental, state, federal) would potentially conflict and delay progress. It is clear that consistent, fair guidelines are needed to achieve an enterprise approach.

Legacy Systems
Outdated technology is mentioned so frequently that it plays like a tired, old song—one which is clearly not being heard even though the risks are great. The risks are that the systems will become increasingly expensive to support, eventually becoming unsupportable. The current issue with most legacy systems is that making enhancements is very difficult. Fortunately most of the large IT system projects currently underway will replace legacy systems.

Accessibility
Accessibility is important both to NC DHHS staff and to external business partners. It is common for employees to work in the field (such as conducting inspections) or actually be located in the field (such as vocational rehabilitation counselors that are located in the schools). In most instances, these employees are not able to access information resources back at the office nor do they have mobile tools, such as laptops, that would greatly improve their efficiency in remote locations and assignments. Instead, these workers must take notes and complete paper forms and then enter them electronically once back at the office. They are also not able to answer questions where they have to look up information. These workers need the tools to work effectively remotely and be able to access the information resources of the department. Also, employees who are not field workers would benefit from being able to access information resources when there is need to work from home.

Additionally, for those divisions with remotely located staff, it is difficult to have routine staff meetings that do not involve the extra expense and downtime of travel. Videoconferencing technology would not only allow face to face communication, but would also be available for remote training and communications with constituents.

Another accessibility issue reported related to external business partners (such as universities, non-profits and other state agencies) being able to access information. This type of access would be more than what is available to the general public through public web sites.

While IT enables effective distribution of department information to employees and enables employees to manage their own human resources information online, not all employees at NC DHHS have computers. This staff includes nurses in the hospitals, custodians, and maintenance personnel. To ensure that information management strategies do not leave out these employees, the department needs to make the resources available to them through kiosks or other means.

Finally, any application or web site developed in the department must be made accessible to people with disabilities of all kinds, both mental and physical. Many in the department are already aware of this need, however, it is very important that it continues to stay in the forefront and not become an afterthought in the development process.

Achieving Operational Excellence in Information Technology

To achieve operational excellence in information technology the department should take steps to address the opportunities related to enabling the business, taking a holistic approach to information technology management, and accessibility to information resources. Critical to achieving success in these is establishing department wide IT governance.

The first step in establishing IT governance is creating an IT governance board staffed primarily with business leaders from the department, not tech savvy IT leaders. If IT is going to most effectively support the program and service delivery needs and operational needs of NC DHHS it must be driven by business needs. The tech savvy leaders are not the most informed about those business drivers. At some point, every IT decision is ultimately a business decision not a technological decision. Furthermore, since there are very few business decisions now that do not also impact, or are potentially impacted by IT, the board must be supported by business savvy technology professionals. Note that as of the writing of this plan, an initial directive to establish an IT governance board has been created.

The primary purpose of an IT governance board is to ensure that business needs drive technology decisions and that a holistic, organization-wide approach is taken for IT initiatives. This should include making sure that all divisions that can benefit from an initiative are included in the initiative, preventing and reducing redundancy and overlap, and encouraging synergies through collaboration. To be successful, the IT governance board must be vested with decision making authority established through a secretarial directive. The board must also represent the interests of the department, not any single division. Obviously there will be times when the interests of different division conflict, or when one division may feel underrepresented in an initiative. To address these conflicts, an arbitration process should be established with an unambiguous dispute resolution process.

As a governing body vested with authority, the IT governance board will be able to break down barriers to the most effective use of technology, such as fears of blending funding streams when it is allowed and sharing data. It should also prioritize spending to focus IT where it will have the greatest impact. The board must also ensure that the intended business benefits or outcomes of IT investments are achieved. The board is also a place where the visibility of potential IT impact on the department can be raised to ensure that IT is included in the planning process.

As the IT governance process is established, it will likely be necessary to form committees that support the IT governance board. For each committee established, there must be a short charter clearly defining what the committee is, why it exists, and to whom it is accountable. Furthermore, every effort must be made to ensure that the area of responsibility of each committee does not overlap. This is very important as overlapping areas of responsibility will slow down the decision making processes.

In addition to establishing an IT governance board as described, the directive for DIRM should be reviewed and strengthened. In order to implement a holistic approach to IT management in the department and realize optimization in efforts to consolidated, centralized and standardized IT utilization, DIRM's new role must be clearly outlined in its directive.

As part of the whole IT governance process, business and IT planning and analysis must occur on an ongoing basis. Much was learned about the current business drivers in the department during the process for creating this business plan and the subsequent IT plan and IT architecture. Arguably the most valuable part of the process was the conversations that were had and connections that were made. While the resulting plans are valuable, what will be even more valuable is keeping the conversations going and continuing to establish important connections.

Even with the creation of a governance board, lack of funding could undermine both one-time and recurring needs. Each year the department struggles to locate enough money to cover basic IT operating costs, and during the last expansion budget requests, all but one of DIRM's expansion budget requests was denied. Beyond establishing business driven IT governance processes, strengthening DIRM's directive and establishing ongoing planning processes, the department must have the proper human resources and funding to ensure that IT is managed most effectively. Again, this is a need not entirely controlled by NC DHHS.

Workforce

Workforce **is defined as all the people working or available to work in the Department of Health and Human Services. As it is used here, it does not refer to any particular human resource office or function; it refers to the staff in aggregate that performs the daily acts of government within the realm of NC DHHS.**

Current Environment

NC DHHS benefits by having a diverse, experienced workforce of (approximately 19,000 employees) who have strong program and technical expertise and a commitment to serve the public. Skills and education levels range from those at entry level positions with less than high school degrees to professionals with degrees in business, engineering, health, and social sciences, to nationally recognized experts with advanced degrees including PhDs, physicians, psychologists, psychiatrists and attorneys. Of the roughly 3,500 job classifications in the state, NC DHHS employees occupy more than 2,000, demonstrating the scope and diversity of the workforce. NC DHHS employs just over 20% of all government employees in North Carolina.

An example of the difficulty of operating within the current HR system occurred when a position at a division remained vacant for nearly a year for a variety of reasons. When the right candidate was found for the position, it took months to complete the hiring process, even though the candidate was an already existing state employee. This particular instance required significant time from the hiring manager, divisional as well as departmental HR staff, the division director and deputy director and the Secretary. This does not include other staff within the division who had to share the work load during this cumbersome and protracted process. The morale and motivation of the affected employee and others were unnecessarily stressed during the process as well.

Over half of these employees are involved in direct service delivery to the public, usually in specialized settings such as a psychiatric hospital or vocational rehabilitation center. While programmatic and service expertise are primary skill sets, an increasing number of NC DHHS employees spend much or most of their time managing partnerships with private companies, nonprofits, and federal or local governments. In these settings, business expertise in areas such as finance, accounting, contracting and negotiating are the primary skill sets.

Supplementing this workforce are about 2,000 contractors, temporary employees, students and interns. The Division of Information Resource Management (DIRM), which has traditionally relied on a large contract workforce composing up to 40% of its population, is actively recruiting full time employees to replace many contractors in areas where it is essential to retain a knowledge base within the NC DHHS workforce. Progress has been slow, in part because contractors with specialized IT skill sets have been able to command higher salaries than those paid to state employees.

Overall, NC DHHS turnover averages about 15% annually, which translates into a need for hiring 3,000 people each year. Of the more than 300 open positions listed for NC DHHS as of the end of July 2006, more than 1/3 were for critical nursing or nurse aide and related positions in the divisions of Facility

Services, Mental Health, Medical Assistance, and Public Health. Many more positions remain unfilled for clinical social workers, occupational and physical therapists, physicians, psychologists and other health care specialists, and information systems personnel.

Part of the turnover in NC DHHS is due to retirements. By the end of 2006, nearly 20% of the workforce will be retirement eligible, including a high percentage of senior managers. When added to other attrition, shortages in needed skill sets such as nursing, and a highly competitive job market in general, the result often is a very thin skills base in key areas that stresses the workforce and inevitably impacts performance.

The chart on page 31 illustrates another aspect of attrition. Fully 30% of NC DHHS employees have from one to five years of service. After five years, however, the percentages drop rapidly, indicating that the department cannot sustain new employment for a large percentage of its workforce. This attrition at the front end combines with retirements at the back end to squeeze the resources in the middle which too often lack the numbers and the expertise to perform effectively.

For example, in almost every division contract administration has suffered by turnover of experienced administrators who are primarily responsible for writing the Statement of Work (SOW) that is the key portion of contracts. The SOW includes programmatic requirements, funding sources, performance measures, and payment and compliance criteria. Administrator mistakes, omissions, and rewrites extend an already burdensome approval process, increasing costs and often resulting in missed deadlines. Many contracts end up with inadequate performance criteria or program/service specifications because there are not enough qualified resources to review and revise all of the documentation. [1]

NC DHHS managers almost universally complain that they cannot offer attractive wages to hire qualified candidates, especially in nursing, engineering, and information systems. The Division of Social Services and Division of Mental Health/Developmental Disabilities/Substance Abuse Services have found that wages at the county level often exceed those paid by the state so that recruiting experienced personnel from county offices is difficult; and, in the case of executive personnel, nearly impossible.

Like other state departments, NC DHHS wages have fallen behind market averages. In the period 2000-2005, state wages increased at less than ½ the rate of inflation. Even a generous 5.5% increase in 2006 will do little to close the gap against inflation, projected to be over 4% this year. With inflation projected to be higher in coming years and with continued pressure on the state budget, the prospects of achieving market equity soon are not good. As discussed in Management Vision and Control, the department has initiated LeadershipDHHS, a program that seeks to identify and develop future leaders in NC DHHS. While this program is not a solution for the lack of succession planning in the divisions, it has been well received and is a positive step to address some of the turnover and recruitment issues that otherwise seem intractable.

Key Operational Issues

During the development of this business plan, top managers of divisions and offices throughout NC DHHS were interviewed. By far, the most frequent and consistent comments centered around human resource issues and the difficulty encountered by managers attempting to navigate the state's personnel policies and regulations. Managers were nearly universal in their opinions that if one thing could be fixed in state

[1] Those who have studied the contract process in NC DHHS comment that sometimes the process involves *too much* review by individuals or functions who do not add value to improving the end product. Whether multiple reviews add value, and whether they are a product of poorly written contracts or are a manifestation of the bureaucracy at work, or both, is a subject of debate.

Government, their choice would be the "personnel system." By this, they mean a broad range of personnel issues including classification and pay for performance, recruitment and personnel selection, disciplinary appeals and grievances, contracting, organizational responsibilities, and training. Personnel reform in the public arena is not easy. It is a lengthy, complicated process requiring political consensus of diverse constituencies and usually has mixed results. Still, several states have dealt with the issues and claim progress in many areas. These states include:

Arizona	Georgia	Massachusetts	New York	Texas
California	Illinois	Minnesota	Ohio	Washington
Colorado	Louisiana	Nebraska	Pennsylvania	Wisconsin
Florida	Maryland	New Mexico	So. Carolina	Virginia

In North Carolina, the few efforts to change the system seem to have occurred in isolation with little or no public debate and have not had a significant impact in changing the work environment for state employees.

One division referred to legislation ratified in 1997 that required personnel policy changes to ensure that only those applicants who clearly exceed job requirements are hired. The subsequent NC DHHS Merit-Based Employment Plan defines "highly qualified employee" and directs that "only applicants designated as highly qualified shall be interviewed" for open positions. In actuality, the policy appears to be ineffective in some divisions. While recognizing that an experienced workforce is essential, a senior executive lamented that "The state's primary criteria for filling a job seems to be longevity rather than skills and abilities—in contradiction to the General Assembly's intent in producing the Merit Based Employment policy."

When asked for examples, managers relate experiences where they have spent weeks or even months justifying new hires, transfers, classification changes, or pay adjustments to obviously qualified employees. Managers spoke of instances where HR denied requested pay grades because the state's job specifications either did not recognize or did not assign significant value to operational skills such as business, finance, and contracting. "Too many of our job specifications are clinical," complained one manager, "and do not adequately reflect operational expertise needed in today's world."

Some divisions have had success in negotiating the complicated, bureaucratic HR process, while other divisions have simply given up their attempts to advocate for needed changes. NC DHHS Human Resources does an admirable job in "managing by exception" to respond to management requests and negotiate the personnel bureaucracy to achieve results. The problem is that these are work-around efforts and do not have any systemic impact. Rules, regulations, legislation, culture, and lack of autonomy all conspire to inhibit the department's efforts to move faster and respond to the competitive labor environment.

To address non-competitive pay issues, in 2005 DFS was able to obtain a one time special increase for many employees in nursing classifications. Other techniques used to obtain increased pay for high performing employees include creating vertical reporting structures that create unnecessary supervisory positions, documenting increased scope of work to obtain in-range increases, and petitioning OSP for job reclassifications. All of these activities are time consuming, are often artificial, and ultimately do not solve most of the issues surrounding employee compensation. In fact, other problems may arise such as perceived inequity in the workforce among employees who do not benefit from special increases, poor communications across or up and down the vertical reporting structures, and inaccurate descriptions of job duties or requirements.

Proponents of personnel policy reform are at odds with an embedded culture that encourages homogeneity in pay and performance. Because many managers try to work around a system that is not meeting their needs, HR all too often is required to be the enforcer rather than the enabling business partner.[2]

Other change initiatives have proved to be difficult. In the past several years there has been a major effort to introduce a new career banded job classification system in NC. Briefly, career banding (also referred to as "broadbanding") is a way of changing from traditional, narrowly defined job classifications to a system of broad occupational career paths. Career banding is not an end objective; rather, it is a means to an end, that being to provide more flexibility in pay progression, competitive recruitment of quality candidates, and advancement within the bands based on performance or achievement of established competencies.

As part of the implementation effort, career banding was piloted in the state's information technology sections. In explaining the system in the context of retention and recruitment, the Office of Information Technology Services (ITS) writes "… broadbanding is increasingly popular in the private sector. In addition to being used to bring salaries in line with performance it is a motivator towards creating more of a team environment, breaking down barriers, and instituting cultural change." [3]

Despite these positive statements, career banding in this state has been suspended, largely due to opposition from constituencies that either do not agree with the goals or do not believe that the issues have been articulated properly in public debate. While the benefit of career banding to state employees may be debated, NC DHHS managers mutually agree that the present system of classifying and rewarding employees must be reformed if the department is to move forward.

Despite the setbacks, at least one change initiative is proceeding. As stated in the NC DHHS Human Resource profile included in Part II of this business plan:

> NC DHHS management and HR must participate more fully as partners in strategic planning for program operations. Improved technology through implementation of a robust Human Resource Information System (HRIS) is a key to helping HR become consultative and less transactional by redirecting resources to organizational planning and workforce development. Moving to a consultative HR is enabled by HRIS providing a mechanism for management to access HR information, including more involvement in workforce planning. In addition, substantial numbers of NC DHHS employees have internet or intranet access, permitting more educational offerings to be developed by HR as web-based classes.

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[2] The following quote is from a white paper published by the Pioneer Institute for Public Policy Research:
"Unfortunately, civil service rule rigidity and enforcement have become something of a self-fulfilling, self-reinforcing proposition. As civil service systems have become more rigid, the inclination on the part of agencies to sidestep the rules has increased and the inclination of central personnel departments to crack down on rogue agencies has increased proportionally. Growing numbers of jurisdictions—including states and localities—have been able to break this cycle, however. In such places, there has been a gradual but significant shift in the role—and even more important—the attitude of the central personnel office. In at least two dozen states, personnel executives are working hard to reengineer their relationship with their agencies. Some of the leaders in this effort include Florida, Nebraska, Michigan, Connecticut, Wisconsin, Kansas, Washington, and New York. In these states, personnel executives have begun to view themselves as consultants who work for their "customer" agencies." (Walters, Jonathan, Pioneer Institute for Public Policy Research - White Paper No. 13, September, 2000)

[3] North Carolina Office of Information Technology Services, IT Professional Retention and Recruitment, 2006

It remains to be seen, however, whether a technology enhancement will truly enable change where the system has traditionally rewarded regulation, rigidity, homogeneity, and compliance. The bottom line is that the tools given to managers today are not adequate to deal with the host of workforce issues facing the department. NC DHHS Human Resources recognizes this, but is not empowered to act independently of the rules and regulations established at state-level.

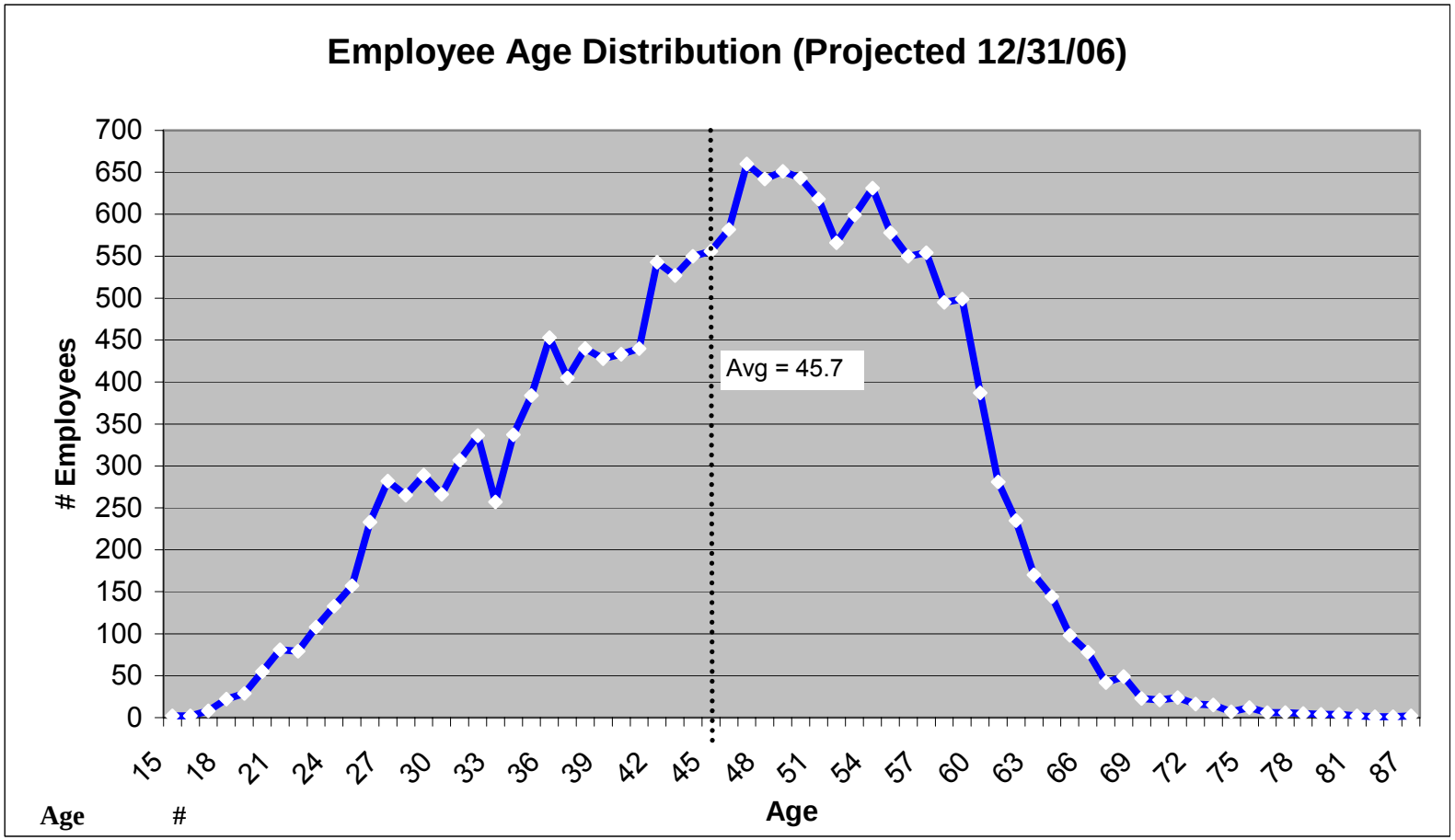
Achieving Operational Excellence in Workforce

In the absence of comprehensive policy reform at the state level, there are certain tools in NC DHHS that can be used to measure improvement in workforce status and performance. In addition to those presented in the Human Resources profile in Section Three of this document, operational managers must assume responsibility as managers of the department's "human resources." For example, even though NC DHHS does not have a formal succession planning process, this does not prevent individual divisions and offices from participating in the LeadershipDHHS program and establishing their own succession plans for managerial and supervisory positions. To establish these succession plans, managers must have the flexibility and authority to identify and develop the best and brightest candidates and designate them as high potential employees.

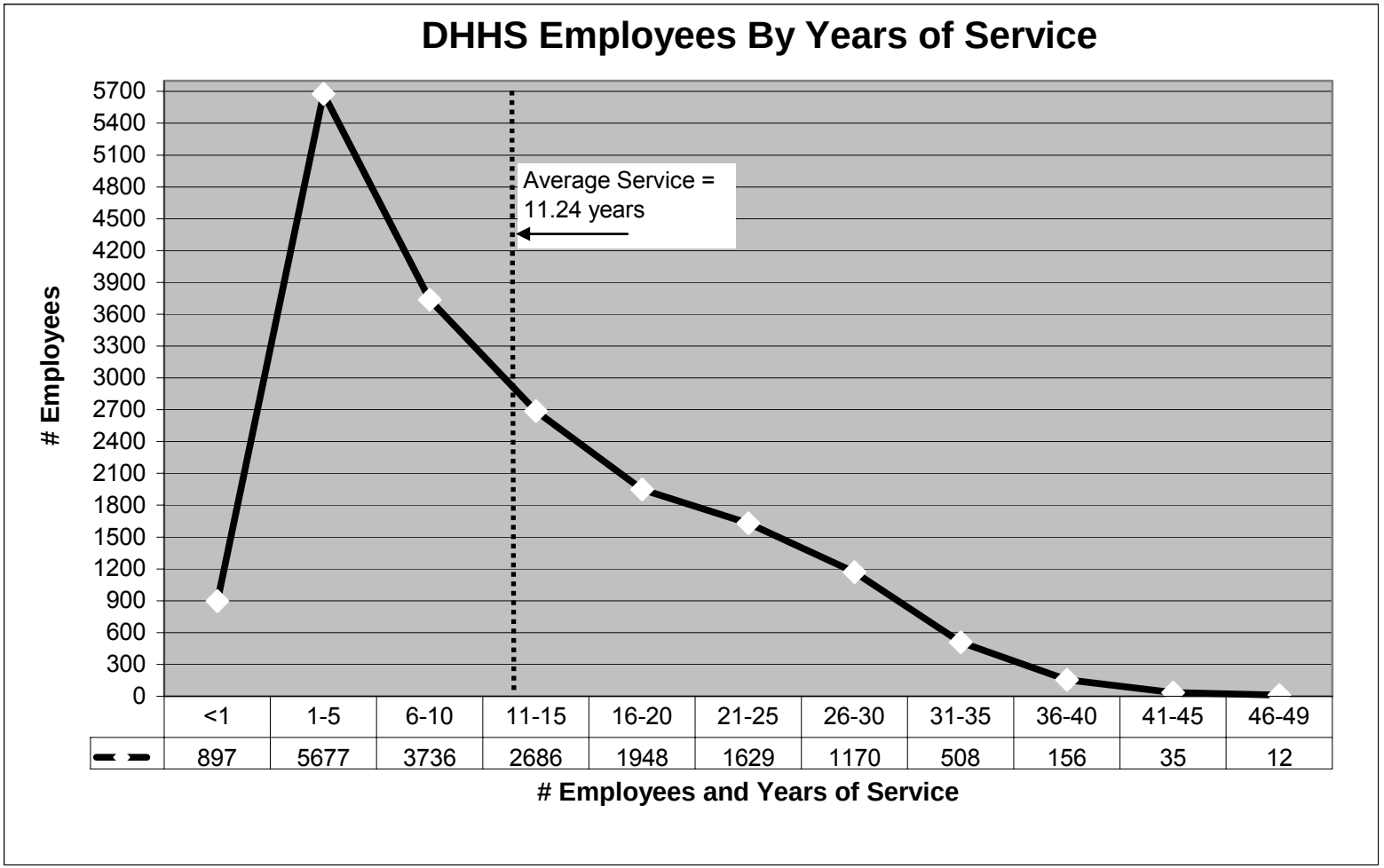
Directly tied to these requirements are management tools and best practices that will help to support workforce development. Perhaps the most important of these is already underway and will be implemented in 2008 – a new human resource information system (HRIS) developed as part of the BEACON project (Building Enterprise Access for NC's Core Operations Needs). BEACON will replace the old Personnel Management Information System (PMIS), a DOS based system that is 25 years old.

HR must ensure that all divisions and offices annually update job descriptions and work plans to reflect the actual competencies, skills, and abilities required for each position. Managers must identify and fund individual training requirements, both technical and developmental, that correlate with needs as identified in work plans, performance reviews, and departmental expectations. When it becomes necessary to fill a job, the hiring process must be simplified so that candidates can be identified and hired within weeks, not months. While these workforce issues are basic and perhaps taken for granted, NC DHHS has not consistently implemented them across the organization.

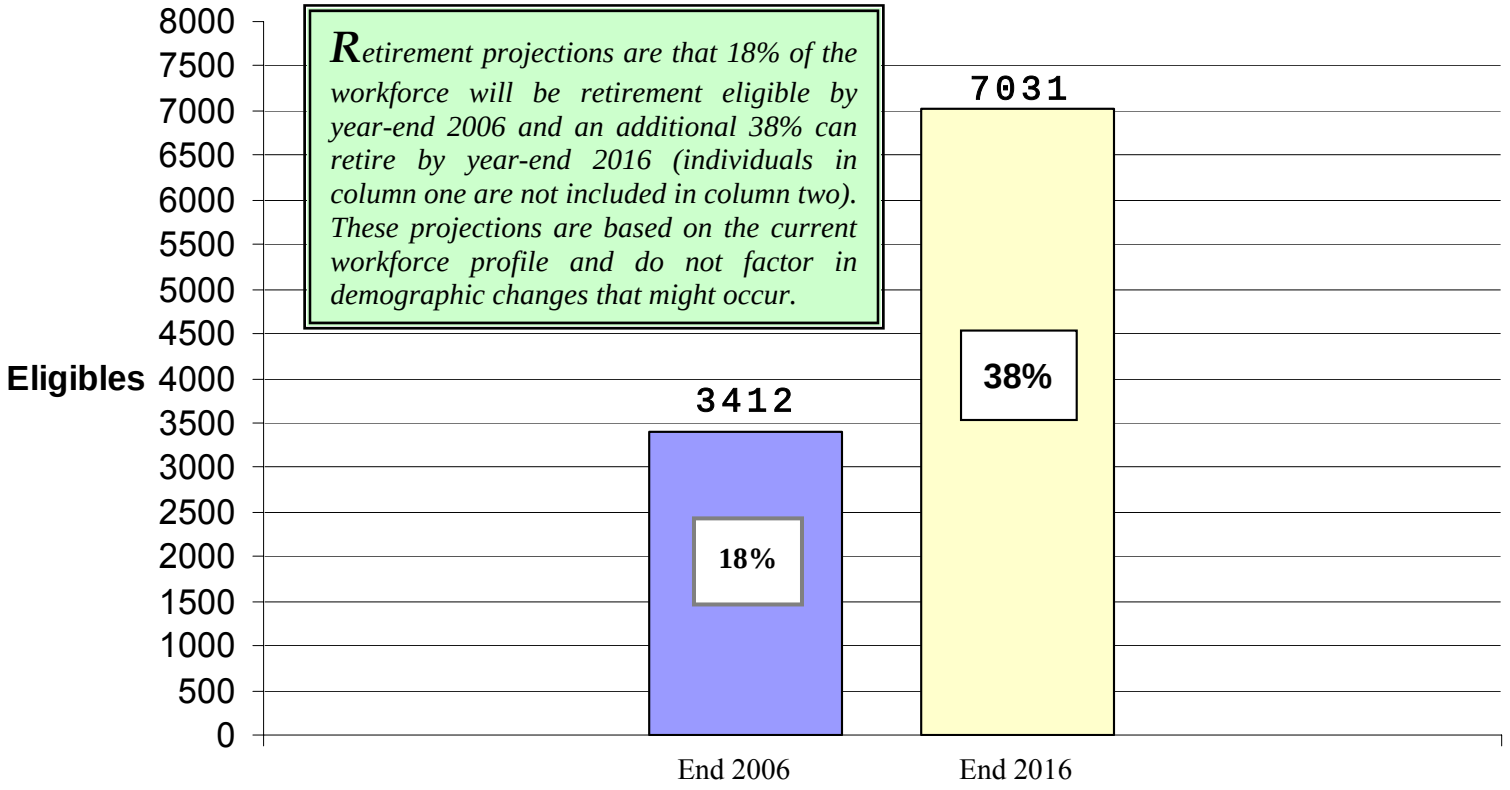
Even though much of the HR agenda is externally controlled through the State Personnel Act (such as career banding and classification, pay for performance, etc.), NC DHHS management will continue to advocate for progressive changes that will aid—not hinder—management in recruiting, retaining, and rewarding good performers



Age	#																				
15	2	**23**	108	**31**	307	**39**	428	**47**	660	**55**	578	**63**	170	**71**	24	**79**	4
16	2	**24**	133	**32**	336	**40**	433	**48**	642	**56**	550	**64**	144	**72**	16	**80**	4
17	8	**25**	157	**33**	257	**41**	440	**49**	651	**57**	554	**65**	98	**73**	15	**81**	2
18	22	**26**	233	**34**	337	**42**	543	**50**	643	**58**	495	**66**	78	**74**	7	**82**	1
19	29	**27**	282	**35**	384	**43**	527	**51**	618	**59**	499	**67**	42	**75**	12	**85**	1
20	55	**28**	265	**36**	453	**44**	550	**52**	566	**60**	387	**68**	49	**76**	6	**87**	2
21	81	**29**	289	**37**	405	**45**	556	**53**	599	**61**	281	**69**	23	**77**	6		
22	79	**30**	266	**38**	440	**46**	582	**54**	631	**62**	235	**70**	21	**78**	5		


DHHS Employees By Years of Service
Employees
5700
5400
5100
4800
4500
4200
3900
3600
3300
3000
2700
2400
2100
1800
1500
1200
900
600
300
0
Average Service =
11.24 years
<1
1-5
6-10
11-15
16-20
21-25
26-30
31-35
36-40
41-45
46-49
897
5677
3736
2686
1948
1629
1170
508
156
35
12
Employees and Years of Service

DHHS Retirement Eligibles



The "Retirement Eligible" population was estimated based on projections for 12/31/06 and 12/31/16. "Retirement Eligible" is defined as any employee who will achieve the following by those dates: (1) 30 years of service regardless of age (2) Age 50 with at least 20 years of service (3) Age 60 with at least 5 years of service (4) Age 65 with at least 5 years of service.

Program and Service Delivery

In a private sector business plan, this functional area would be called "Product" and would address such issues as: is there still a need for the product, is demand for the product increasing or decreasing, are customers of the product satisfied, have our customer needs changed, and who else is manufacturing the same or similar product. Many believe that government does not have a product, but in fact it does—government's product is the service it delivers to the public. In The Change Agent's Guide to Radical Improvement, Ken Miller defines a product as "something created by work which can be given to someone else to achieve a desired outcome." This is the definition used in this business plan.

Current Environment

Programmatic expertise within NC DHHS is very strong; and, supported by federal and state requirements and funding, the department provides a wide-array of services to North Carolina residents. However, all services are under stress since demand continues to outpace resources. As part of this business planning process, NC DHHS agencies provided information about the impact of demographic factors on their operations. It is important to note that in the top ten issues mentioned in the programmatic divisions of NC DHHS, workforce, information technology, and program and service delivery were the top three. In fact, they were mentioned eight of ten times. This indicates the strong need for operational support improvements around HR and IT to improve and support long term stability of program performance and delivery.

Not surprisingly, in the operational units, program and service delivery is not mentioned. However, mentioned five out of ten were workforce and IT—again showing the strong link between HR and IT to provide the operational strength of the department necessary to efficient program and service delivery. (See Appendix 4 for a summary of all demographic influences identified during this business planning process.)

As expected, programs are feeling the impact of North Carolina's population growth, an increase in the number of elderly residents, a surge in the immigrant population, increasing demands for multi-lingual and multi-cultural state and local staff, economic fluctuations, health care cost increases and other factors. To meet these demands, program and service delivery must change for two different reasons—one is external and based on demographic trends and external factors and the second is due to changes in policy around service design and delivery.

As demand grows, staff serving the recipient populations need to be flexible enough to change as well; yet NC DHHS is experiencing shortages of certain specialties (nurses, psychiatrists, dentists, architects, for example) and often is trying to place people with new skills into positions with out-of-date job classifications and compensation. Some of these skill shortages are national in nature and reflect an imbalance between supply and demand; others are shortages created by the unwillingness of these highly trained and skilled professionals to work for the state at below market rate salaries. Additionally, North Carolina's more diverse population places language and cultural competency requirements on the way we communicate and deliver services. This combination of internal handicaps paired with the external limitations and demographic changes is stressing the department's service delivery system.

Over the last several years there has been a national emphasis on programmatic outcome expectations, consumer choice, seamlessness of service delivery, providing services in the community rather than in institutional settings, designing services around evidence based practices, cost containment and a growing awareness of the need to move from treatment of chronic problems to prevention. All of these are excellent improvements to program and service delivery because they strengthen the benefit of the service and lead to greater efficiencies in the use of resources; but to respond to these new expectations, the department must be nimble enough to change in a timely manner. Yet program and service redesign is impeded in an organization using legacy systems from the 1970s, an antiquated HR system and restricted funding streams.

Key Operational Issues

Throughout the years North Carolina has developed a wide network of community partners with and through whom services are delivered to the people. The DSS and DPH state supervised, county administered systems have fostered the development of strong networks within the one hundred counties which facilitate resident access to services. The Community Care of North Carolina (CCNC) program has built a strong network by partnering with local clinics and hospitals to further reach out to those with a need for primary health care who reside in underserved areas. Creation of the Local Management Entities to push mental health, substance abuse and developmental disability services away from institutional settings and into the community further expands the state-wide network supporting service delivery. And, of course, there are numerous regional staff which allows the state to have a presence, in some cases deliver services, and conduct outreach and supervision. Such a large network of providers does, however, require communications, tracking and monitoring systems to fully maintain control and supervision.

Additionally, while this network meets many program and service outreach and delivery goals, it is hindered by NC DHHS' inability to share client data and to conduct cross program case management. An example of how the department is working to overcome this obstacle is NCFAST. NCFAST will facilitate better eligibility determination and case management, but this system has been evolving over a lengthy period of time and faces regular funding scrutiny with every change of administration and legislature. Such delays undermine county confidence that NCFAST will ever see the light of day, it slows their adoption of the system, and it undermines the credibility of the department with its major service providers.

Making improvements in program and service delivery is often a protracted and frustrating effort because of difficulties reaching consensus among the various stakeholders at the federal, state and local level. Past efforts, such as NC-CAN and INSYNC, to develop a shared database to support child welfare and economic benefit programs were hampered by differences over use of funding streams, data "ownership" and access, the scope of a technology solution and vendor selection. Most agree that such a system will provide more accurate benefits, support more consistent eligibility determination and reduce errors, allow the sharing of data about who is receiving services and save considerable time by reducing paperwork and duplicate data entry. Additionally, the Child Fatality Task Force through the intensive fatality reviews has found that approximately five deaths a year could be prevented if there is better data sharing among county case workers. In 1999, NC FAST was started to accomplish many of the same goals. A lot of good work has been done over the ensuing years, and there is growing support at the county level for such a system. Although currently slowed by contracting delays, there are high aspirations that NC FAST will realize significant process savings and greatly improve service delivery.

Technology is changing fast in the healthcare field. Tele-medicine allows doctors to remotely interact with patients. E-health records allow for faster and more accurate recording, transmitting and sharing of individual patient records. While these new technologies offer amazing efficiency, improved service, and allow for

extending care, the state is building the new Butner hospital without the appropriate information infrastructure. Without additional funding support, a state of the art building will operate without the appropriate clinical systems.

As mentioned previously, NC DHHS has built a program management database (PMD) which stores program and service information in a web based, central location easily accessed by management at all levels. The PMD contains such information as funding, program and service description and goals, outcomes and output measures. Last year the department started a program review based on the information in the PMD. Continued utilization and enhancements to the PMD for such collaborative discussions will further improve programs and services delivered to the public.

Achieving Operational Excellence in Program and Service Delivery

It is in the delivery of services that NC DHHS most intimately interacts with North Carolina residents and conducts the work it is mandated to do in providing for the people and securing both their safety and wellbeing as well as the economic stability of the state. As mentioned in the above sections, NC DHHS is making improvements in many areas, but there is much that needs to be done to achieve operational excellence in program and service delivery.

One way to achieve excellence is to keep the focus on customer service when evaluating and designing programs and services to meet specific needs of the population. DMH/DD/SAS is already in the process of moving services from institutional to community settings, making services more accessible and seamless through our local network of partners, and offering a wider array of services to meet varying consumer needs. Routine use of a nearly completed web-based customer service survey tool will provide an additional avenue for getting feedback from consumers and using that information to improve service design and delivery. As mentioned in the section on Communications, NC DHHS is in the process of redesigning its website so that the public can get quicker and easier access to program and service information. Additionally, the telephone based information and referral service, Care Line, and the relatively new CareLink, the web based I&R service, have recently expanded to provide greater customer service.

Graphic information system (GIS) enabled data allows for better management of emergency situations and program and service distribution and allocation; and many NC DHHS agencies, from DPH to Property and Construction and DFS, expressed a desire to make greater utilization of this technology. The Division of Services for the Blind specifically mentioned the need to develop closer interaction with manufacturers of assistive technology because advances in that field offer improved independence for their constituents.

The PMD program review process referred to earlier is breaking down information silos, identifying areas for improvement and creating opportunities for greater collaboration—all extremely important since more than one agency may serve the same intended beneficiary. Additionally, the usefulness of the PMD will increase as the system is expanded to include the contracts database and the subrecipient monitoring database and as we partner with OSBM in their results based budgeting initiative, provide PMD information for the grant reports and use it to populate their CRIS system.

Since many divisions serve similar populations, and since the availability of data is critical to establishing performance measures, it has become increasingly clear that more client specific data needs to be shared. Granted, confidential information must be protected, but opportunities exist to provide better service and make better utilization of resources when information can be shared and analyzed for multiple uses. One

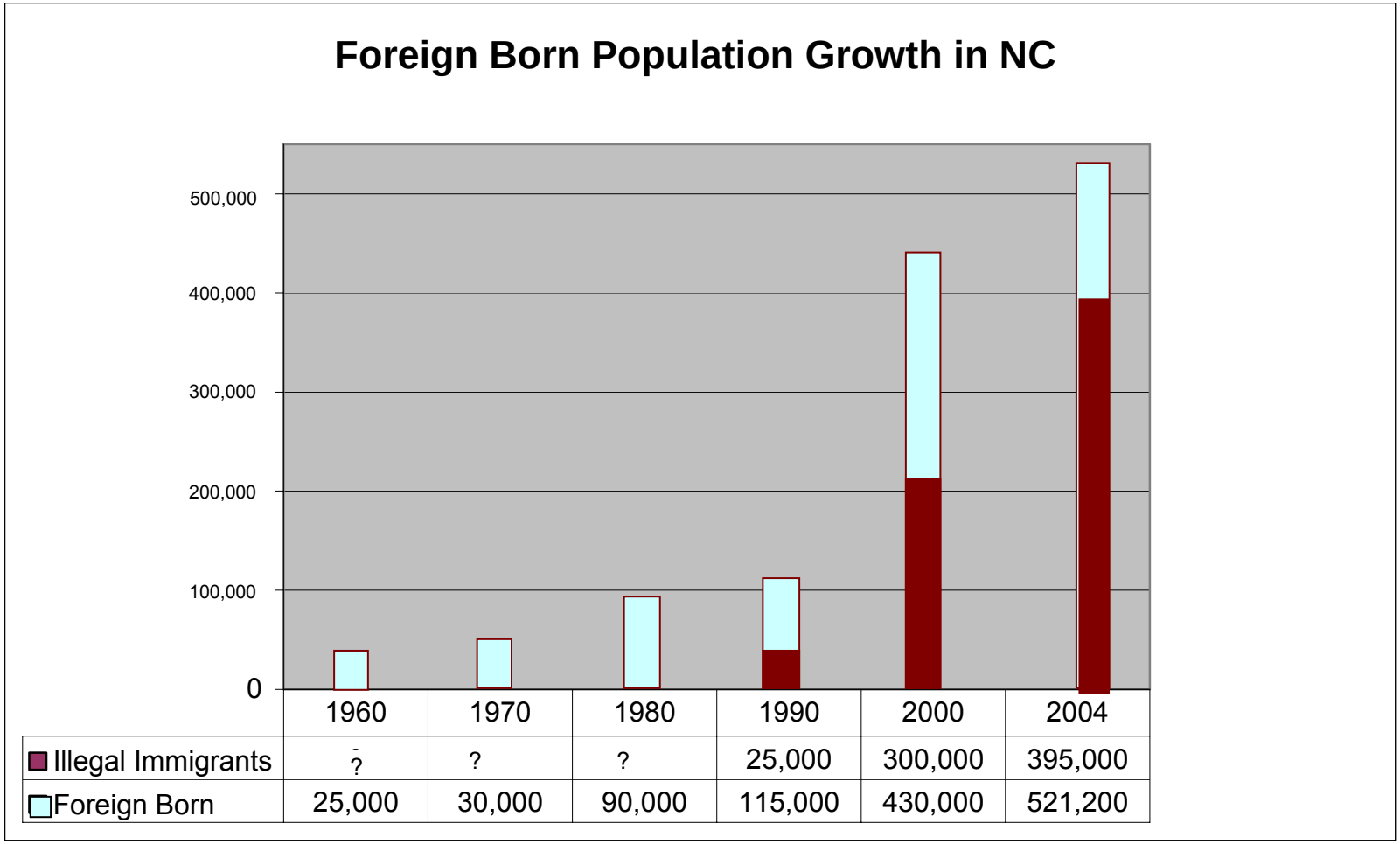
opportunity to do this is to expand on the already existing Customer Service Data Warehouse (CSDW) and to create greater flexibility in how that data is used.

Additionally, several agencies mentioned the need for more extensive outreach to residents in need of service. Others are struggling to meet growth in demand for services without reciprocal growth in resources and are trying to develop better cost containment strategies without impacting level of needed assistance. DPH believes that program design and outreach would benefit from better race information. Apparently this is not collected as extensively as desired, mostly because in-take staff are often reluctant to ask such questions of the public needing assistance.

In sum, programmatic expertise and commitment is strong, and creative and technical solutions are being utilized, but opportunities exist for improvements. DIRM has played a significant role in the development of the PMD, design and maintenance of the CSDW and development of the customer service survey tool mentioned above. But their limited staff resources and the department's IT funding limitations make these improvements protracted and frustrating. The department will continue with these and other improvements to the extent that human and financial resources are available.

Summary of Demographic Influences Impacting NC DHHS Programs (From Responses to Business Plan Questionnaires)

SUMMARY			
Group	**Trend**	**# Response**	**Rank**
A	Aging Population	14	1
C	Immigration issues, especially Hispanics who don't speak English	13	2
B	Growth of eligible populations (Aged, Children, Disabled, Poor, etc)	10	3
F	Budget shortfalls / issues	10	3
L	Unemployment / layoffs / plant closings	7	5
E	Cost of care / services increasing	6	6
D	Individuals / families in poverty or minimum wage	5	7
Q	Decrease in providers / unavailability of providers or services	5	7
U	Decrease in rural industries / movement from rural to urban	4	9
G	Natural disasters	3	10
H	Technology advances, including medical technologies	3	10
K	Increase / transition to community services	3	10
M	Multiple disabilities / conditions	3	10
P	Aging Workforce	3	10
S	Aging Facilities / Equipment	3	10
T	Recruitment issues / shortages of nurses and other professions	3	10
I	Rise / Fall in Economy	2	17
R	Federal teaching requirements	2	17
V	Job market skills changing	2	17
W	Growth in uninsured	2	17
X	Increasing HS drop out rates	2	17
J	Increase in single parent families	1	22
N	Unfunded mandates	1	22
O	Obesity and associated health risks	1	22



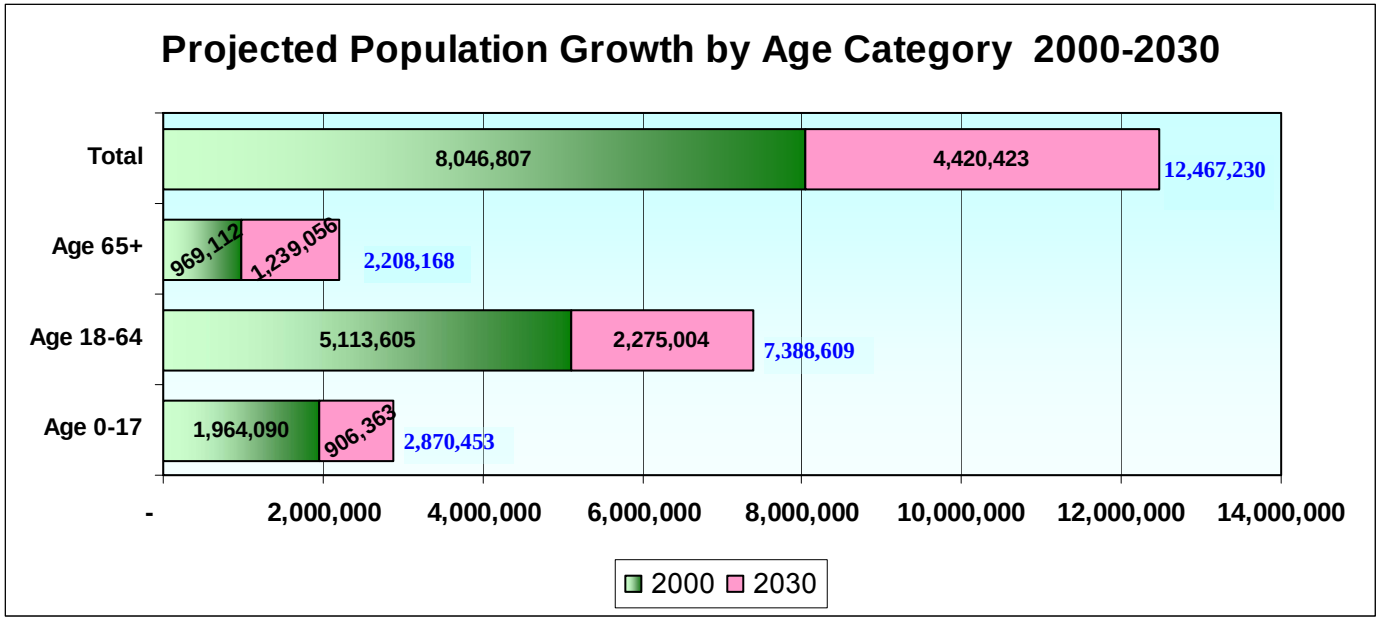
In 2000, the unauthorized immigrant population in North Carolina was approximately 206,000. "Estimates of the Unauthorized Immigrant Population Residing in the United States: 1990-2000," Office of Policy Planning, U.S. Immigration and Naturalization Service, January 2003. Other figures provided by the Pew Hispanic Center.

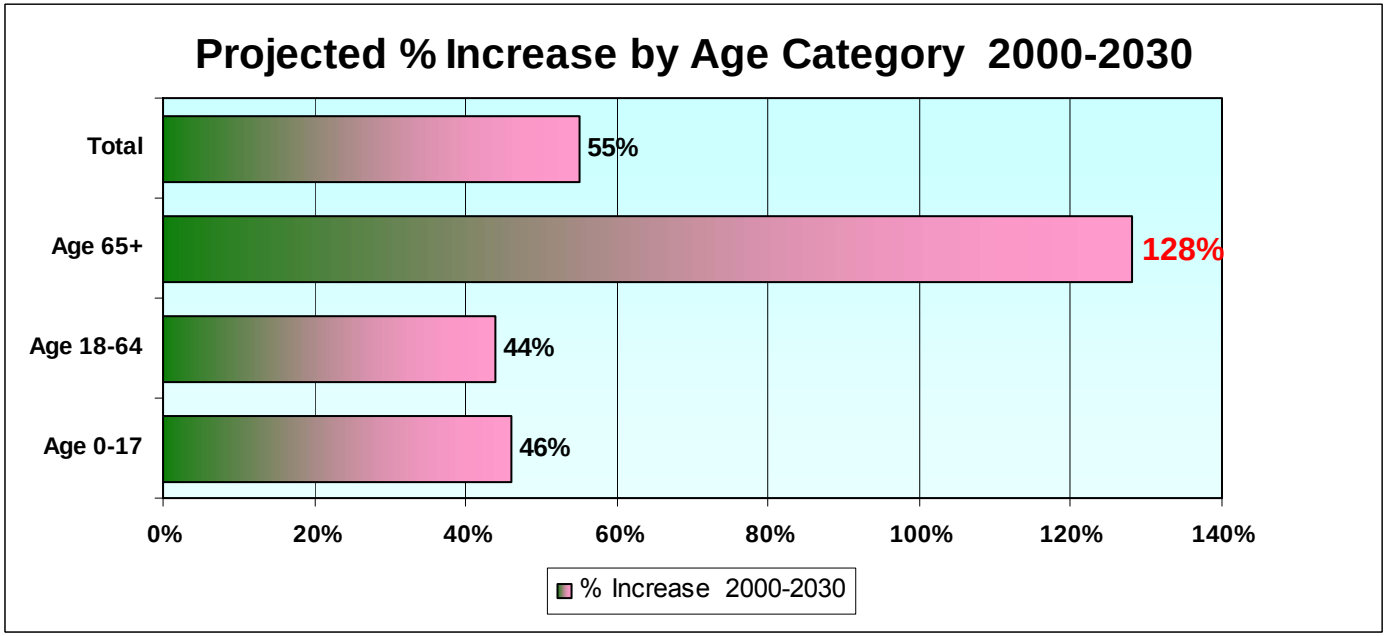
At right are age category projections in North Carolina for the years 2000 through 2030. The first chart depicts growth in number. As one would expect, most individuals fall into the age 18-64 category. The top and bottom categories are about the same, creating a typical bell curve.

The second chart uses the same data but presents it as the projected percentage increase in each age category. In this view, the percentage growth for 65+ is overwhelmingly greater than that of the other two age categories.

Rapid growth in the aged population correlates to rapid increases in services for the Blind, Deaf and Hard of Hearing as well as residential care facilities and social services targeting the elderly.

Source: DHHS Division of Aging / NC Data Center



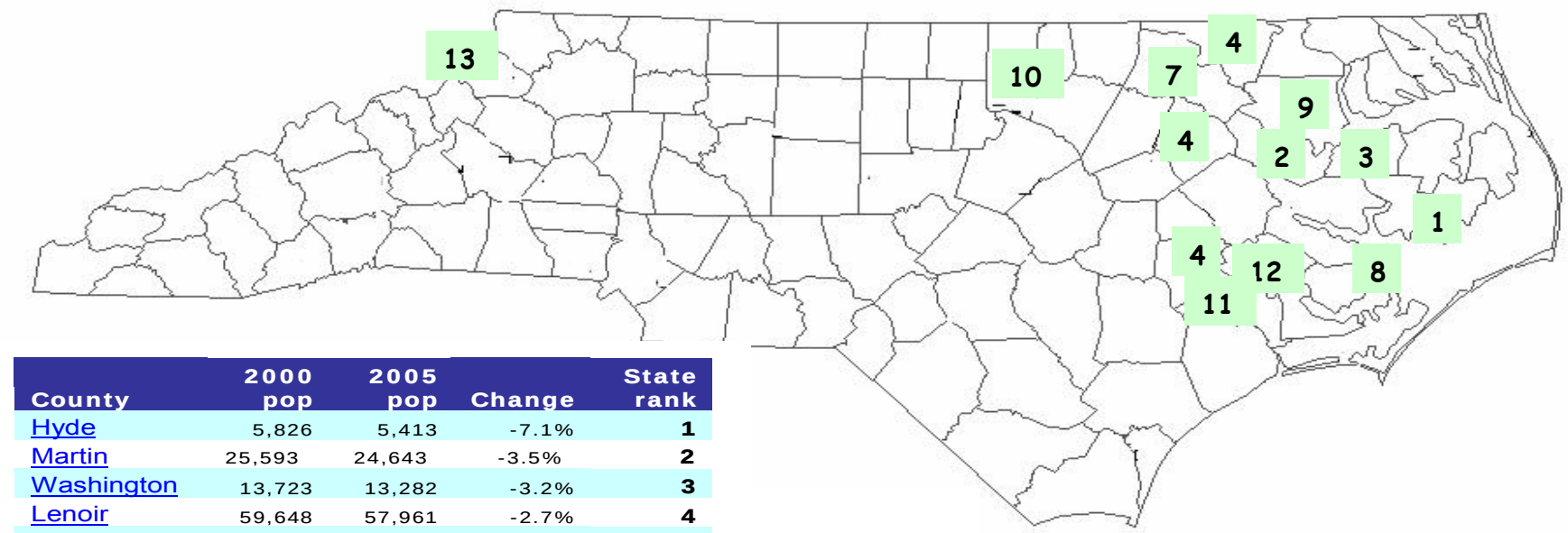


Fastest Growing Counties in North Carolina, 2000-2005

Legend

County	2000 pop	2005 pop	Change	State rank
Union	123,677	162,929	31.6%	1
Camden	6,885	8,967	30.2%	2
Currituck	18,190	23,112	27.1%	3
Hoke	33,646	41,016	21.9%	4
Brunswick	73,143	89,162	21.9%	5
Johnston	121,965	146,437	20.1%	6
Wake	627,846	748,815	19.3%	7
Chatham	49,329	58,002	17.6%	8
Franklin	47,260	54,429	15.2%	9
Iredell	122,660	140,920	14.9%	10

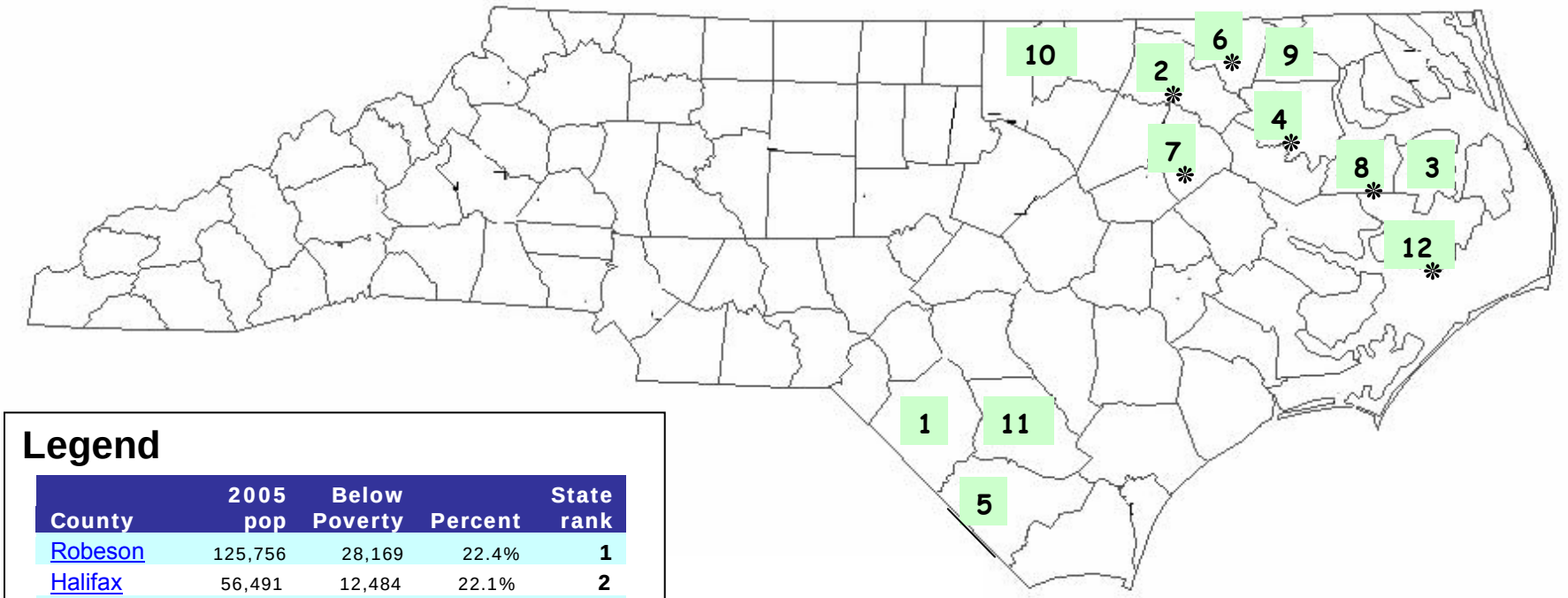
Counties Losing Population in North Carolina, 2000-2005



County	2000 pop	2005 pop	Change	State rank
Hyde	5,826	5,413	-7.1%	1
Martin	25,593	24,643	-3.5%	2
Washington	13,723	13,282	-3.2%	3
Lenoir	59,648	57,961	-2.7%	4
Edgecombe	55,606	54,129	-2.7%	4
Northampton	22,086	21,483	-2.7%	4
Halifax	57,370	56,023	-2.3%	7
Pamlico	12,934	12,735	-1.5%	8
Bertie	19,773	19,480	-1.4%	9
Warren	19,972	19,729	-1.2%	10
Jones	10,381	10,311	-1.0%	11
Craven	91,436	90,795	-0.8%	12
Watauga	42,695	42,472	-0.5%	13

Note: Columbus County experienced 0.0% growth

NC Counties with Most Persons Below Poverty Level



Legend

County	2005 pop	Below Poverty	Percent	State rank
Robeson	125,756	28,169	22.4%	1
Halifax	56,491	12,484	22.1%	2
Tyrrell	4,156	910	21.9%	3
Bertie	19,544	4,026	20.6%	4
Columbus	54,518	11,067	20.3%	5
Northampton	21,782	4,400	20.2%	6
Edgecombe	54,895	10,924	19.9%	7
Washington	13,399	2,640	19.7%	8
Hertford	22,310	4,350	19.5%	9
Vance	43,736	8,445	19.3%	10
Bladen	32,723	6,283	19.2%	11
Hyde	5,567	1,063	19.1%	12

* **Hyde, Washington, Edgecombe, Northampton, Halifax and Bertie were also among the counties losing population in the period 2000-2005.**

Budget and Finance

Although these same terms are used in the private and public sectors, the functions are quite different. In both the public and private sector, budget generally refers to an itemized summary of estimated or intended expenditures for a given period of time, or a systematic plan for the expenditure of a usually fixed resource during a given period, or the total sum of money allocated for a particular purpose or period of time. In both sectors finance encompasses the science of the management of money and other assets, but the tools to exercise this science are very different.

Unlike the private sector where there is a link between an increase in output and an increase in resources to create that output, this link does not exist in the public sector. Government agencies frequently are expected to deliver an increased level of service without an increase in resources.

Current Environment

NC DHHS receives money through a bewildering array of funding streams, federal grants and appropriations. Each division has a budget officer who interfaces with centralized functions in the Secretary's Office, most notably Budget & Analysis and the Controller's Office. B&A and the Controller, in turn, work with finance units at the state level to route information, generate requests, make transactions, and produce reports to keep the state and general public informed of NC DHHS's spending and priorities. All of these activities are monitored and validated and reported on by the Office of the State Auditor.

In managing this financial data flow, it is imperative that the department maintains a high level of interagency cooperation and communication to ensure that current information, work requirements and other demands are effectively and timely conveyed and that all agencies have adequate opportunity to participate in the budget management and development processes. In general, according to numerous interviews, NC DHHS has strong financial controls in place for the proper tracking of funds and expenditures.

Sometimes, the sheer size of NC DHHS is a disadvantage to obtaining needed funding from the state legislature. Too often, it is assumed that because the department has such a large budget, shortfalls will be made up and money can always be "found" to fill in the gaps. In the past, NC DHHS did have some ability to do this, but recent actions by the legislature have taken funds such as lapsed salaries off of the balance sheet, resulting in severely reduced flexibility. This has hurt the department's ability to find money each year to fund basic, recurring items such as utilities and DIRM operating expenses; but the effect goes well beyond to include most operational aspects of NC DHHS.

Key Operational Issues

The Office of State Budget and Management is working on a new "results-based" budget format for the 2007-09 Budget. The intent of Results Based Budgeting (RBB) is to improve the publics and decision makers' understanding of agency mission, goals, activities, impact and funding.

There are many positive aspects to RBB:

- RBB supports the department's performance management initiatives;
- It represents an opportunity to present meaningful information about program purpose and impact to the legislature to direct discussions on funding; and
- It will provide historic information on expenditures and positions at the division level.

Traditionally, the lack of transparency in financial information due to an outdated budget structure makes it very difficult to determine where money is going and for what purpose. While NC DHHS is able to do this to the satisfaction of its auditors, an enormous amount of effort is expended. Results based budgeting will make this information clearer and will enable resources to focus more on the impact of spending these dollars. The systems merger of the Program Management, Sub-Recipient Monitoring, and Contracts databases will provide a tool to make better judgments about how and where dollars are expended and whether performance objectives are being met. This, in turn, helps to inform management about spending priorities, funding overlaps, etc.

A common theme expressed in the divisions is the real and/or perceived funding inflexibility. This manifests in different ways, from the Office of Economic Opportunity, where federal grants mandate where and to whom dollars are to be directed, to Social Services, where funding inflexibility threatens to force the state into a national model that does not address specific needs in North Carolina (see the DSS profile on page 87 in Section Two). To avoid such difficulties, various divisions are exploring waivers that would authorize targeted spending in such areas as Foster Care and Medicaid eligibility.

Sometimes restrictive funding is an illusion and results from over-interpretation of spending guidelines or a simple unwillingness on the part of a program manager to redirect or share funds. It is hoped that initiatives such as results based budgeting, program reviews, performance management, and IT consolidation will generate dialogue about creative, yet legitimate, use of funding streams.

As stated above, inadequate funding is a nearly universal complaint among divisions and offices. While this situation not likely to change, some NC DHHS managers are taking positive steps to reduce the department's financial exposure. DMH, in particular, has placed restrictions on which grants/demonstration project opportunities can be pursued based on (1) priorities for assigning scarce human resources and (2) whether the short term opportunity will require state recurring dollars in the future. This change in focus from decentralized grant pursuit to long term sustainability ultimately will result in a better financial environment for NC DHHS and improved, stable services to recipients.

Prior to 1991, a special NC provision (commonly known as Jordan-Adams) allowed for an automatic inflation factor to be added to budgets for such things as utilities, IT maintenance, and the cost of service delivery. Although codified in 1991 as G.S. 143-10.1A, the General Assembly has ceased appropriating funds for the purposes described. In DHHS, this results in chronic under funding, especially in state hospitals, special care units, and residential schools, and places automatic restrictions on budgets before any other considerations

The Secretary has also expressed a desire to maximize resources by focusing on operational improvement and positive changes in how programs and services are delivered. The Office of Policy and Planning has led efforts in a number of divisions to achieve process improvement, demonstrating that working more efficiently is an effective way to make better use of limited dollars. Chief among these efforts is the centralized Criminal Records Check Unit, where process improvements resulted in reducing a fifteen week mail backlog to zero and total cycle time from six months to less than two weeks.

Divisions are increasingly refining how they monitor and measure vendor performance against contract requirements and are applying outcome based management practices to improve how programs and

services are funded and targeted. Examples of these practices are found in Rural Health, where documented performance standards for NC health centers will buffer funding losses by providing an objective means of distributing available money; and in Child Development, where the division provides specific guidance to counties by requiring subsidy plans to be submitted and by establishing compliance ratings for counties.

Achieving Operational Success in Budget and Finance

With funding shortfalls identified as one of the top issues for the department, NC DHHS should take specific actions that will result in more money flowing in. These actions include pursuing waivers to increase the flexibility of federal dollars that are restrictive and that do not fully address specific needs in North Carolina; obtaining waivers to fund services to targeted recipients without imposing automatic eligibility for other programs and services; embracing the change to results based budgeting; and using tools such as the Performance Management Database to improve the quality and substance of communications to state offices and the legislature, and to ensure proper monitoring of programs and vendor performance as a way to maximize limited funds.

NC DHHS needs to take actions to make better, more efficient use of existing money such as increasing process improvement efforts in all divisions to improve operational efficiencies and streamline service delivery; and improving efforts in grant monitoring and training to ensure compliance with federal guidelines, justify cost allocations, and replace the knowledge base lost through retirements and attrition.

Finally, while recognizing that NC DHHS must pursue promising demonstrations that help to test new programs and innovative ways of service delivery, the department needs to prioritize and reduce grant taking that imposes unsustainable financial obligations on the state. To this end, management should identify and reduce the numbers of federal grants in NC DHHS that establish non-sustainable programs and services. These activities would be facilitated by improved systems to catalogue and track active or proposed grants in NC DHHS.

Communications

Communications **refers to all aspects of organizational communication up and down and across divisions within NC DHHS, including marketing, public relations, and internal communications.**

Current Environment

In most organizations, communications is considered an employee core competency. In NC DHHS, it is more than that—it is fundamental to everything we do, from intergovernmental operations, to working with constituents, advocates, and the general public, to program and service delivery. This section focuses mostly on the human element of communications, but in part touches on events occurring in other functional areas identified in this business plan.

NC DHHS has established strong external communications networks throughout the state. These networks are represented by a host of entities wherever programs and services are rendered, such as social service offices, LMEs, community care centers, health departments, independent living centers, vocational rehabilitation centers, district offices of the divisions of Services for the Blind and Deaf and Hard of Hearing, Regional Resource Centers for the Deaf and Hard of Hearing, and a host of other networks and providers too numerous to mention. External communications vehicles that link NC DHHS directly to the public include the CARE Line in the Office of Citizen Services, call centers in Medical Assistance, Mental Health, and Social Services, and complaint lines in various divisions.

At the onset of her administration, Secretary Hooker-Odom identified improving internal and external customer service as one of her top priorities. Good customer service places a premium on good communications, and this is reflected in many of the policies, directives, task forces and work groups throughout the department. Various forms of electronic media—email, calendaring, teleconferencing, internet—supplement face-to-face communications and are used extensively throughout NC DHHS. Employees share information through on line newsletters produced by the department and by various divisions.

One of the most important means of communicating externally as well as internally is the NC DHHS website and all of the associated links to division, local, state, and federal websites. An accessible "E-government" is increasingly expected among consumers and businesses that interact with government. Historically, NC DHHS websites and linkages proliferated in a relatively uncoordinated manner, resulting in information silos that have to be separately maintained and navigated. The amount of content is impressive, but the structure results in redundant information and maintenance efforts. These inefficiencies are costly for the state and frustrating for the average user who often struggles to find specific information on a particular topic.

The website is currently being transitioned under the leadership of the Office of Public Affairs to an intentions-based design that will organize information in a much more logical way than in the past. While divisions will maintain responsibility for content, NC DHHS will make significant changes to navigation, appearance, and accessibility. Information will be more readily accessed by all classes of users, including

those with disabilities and Spanish language populations. Also, due to the array of different cultural backgrounds of North Carolina's residents, the information will be written at an eighth grade level.

In a department where daily activities are largely governed by rules, policies and federal/state regulations, communicating and ensuring understanding of such information is critical. Under the leadership of the Office of Policy and Planning, NC DHHS maintains an extensive on-line repository of department policies and directives, along with an effective review and approval process utilizing the expertise of policy owners and policy coordinators in every division and office. The Division of Medical Assistance has in place an effective Medicaid policy review process that functions in much the same way. Such processes provide for feedback, discussion, and coordination that otherwise would prove difficult in such a large organization.

Key Operational Issues

Despite the effort and energy devoted to communications in the department, this business planning process revealed a number of opportunities for improvement. A key issue is how information is stored and managed. For a variety of reasons—some historical, some reflecting funding sources, some technical in nature—information tends to be held in silos; that is, information in one area is often unavailable—even off limits—to employees working in other areas, sometimes even in the same division. There are instances where this approach is appropriate, especially where federal or state statutes require restricted access. On the other hand, there are many more instances where restricting the flow of information impairs program or service delivery, encourages duplication of data gathering and storage, and otherwise increases the cost of operations while lowering productivity. This issue, which is further explored in other sections of this Business Plan, has emerged as one of the fundamental change opportunities in NC DHHS; that is, to establish a culture and a technical environment where information is more freely shared across division lines and where ownership is vested with the department and/or the state as opposed to individual divisions or programs.

While it is true that face-to-face meetings are one of the best ways to communicate important issues, they are not necessarily the best way to make difficult decisions. Large meetings are an excellent way to deliver a message or present information in a way that ensures consistency. However, when meetings get too large, the faces and the messages get blurred—particularly if the person holding the meeting is not an effective facilitator. Discussions become diffused and decisions are frequently tabled while more information is gathered that may or may not inform a particular action. In other cases, the right people are not invited to meetings that they should be attending. Understanding the purpose of a meeting – whether it is to share information and facilitate discussion or to make decisions – is a main driver in determining who sits at the table.

If "information is power," then "information sharing" is even more powerful. A number of senior managers have expressed frustration with the inefficient flow of information across division lines. Some have blamed this on organization structure; others say simply that the right people are not in the right room at the right time. Still others cite the technical environment, saying that even when desired information exists, it is unavailable for a variety of reasons including access restrictions, incompatible systems or terminology, or lack of adequate identifiers to verify data.

Beyond access, NC DHHS managers expressed the need for the department to make better use of information at hand. Some operations collect a large volume of complaint information, but fail to analyze it fully to aid efforts in early problem detection and resolution. Taking action in this area is the Division of Facility Services, which obtained a one-time appropriation to upgrade its telephone complaint line to improve call data storage, analysis, and response.

NC DHHS also needs to take a more formal approach to delineating and assigning responsibility for three traditional functional areas: Marketing, Public Relations and Internal Communications. To the extent that these roles are mixed, intended audiences may be underserved or may receive messages in inappropriate ways. A number of divisions express the need for their programs and services to be better marketed to the potential user community. The Division of Services for the Blind, for example, believes that there are a large number of potential beneficiaries who could be served if they were more aware of what the state offered. Lacking marketing resources within their own operations, some of these divisions wish to see this type of service provided by the Office of Public Affairs. This expressed desire for marketing resources (and specialized skill sets) is another example of how new business skills are being identified in the department and could contribute to greater success.

There is a need for divisions to be more proactive in shaping the public's knowledge of NC DHHS programs and services. This type of promotion will tend to increase public support of human services at the same time that it informs potential beneficiaries. DMH/DD/SAS, in particular, has spoken to the difficulty in conveying to the public and legislature the complexities of mental health transformation and impact on local communities.

To a large extent, internal communications in NC DHHS reflects the department's decentralized and geographically dispersed structure. There is no coordinating body for internal communications, although some efforts have occurred through the Secretary's Customer Service Task Force via a focus on the internal customer. By delineating a special role for internal communications, NC DHHS can enhance the quantity and quality of shared information and establish more consistency in the messages being delivered and received.

Finally, in order to shape the message over time, the department must continually improve the way that it listens. In additional to the various networks, call centers, complaint lines, and working groups, NC DHHS has obtained funding for a web-based survey tool to measure, understand, and improve the quality level of programs and services. Clearly communications plans around major initiatives and issues are necessary. There is a saying, "The biggest problem of communications is the illusion that it has occurred." NC DHHS managers have identified lack of feedback as one of their main communications issues. Whether conducted formally through surveys, questionnaires, or complaint analysis, or informally through simply listening better, feedback is a first step in making improvements, being more proactive, and generally doing more to achieve customer satisfaction.

Achieving Operational Excellence in Communications

There is more to communications than delivering a message. For communication of any sort to be truly effective, it should influence behaviors in some positive way--changed behavior is the desired outcome. This is true whether the communication is to an internal audience about organization goals, program and service activities, or process improvement. It is true in external communications when issues are explained to the public or potential service recipients are identified for targeted messages. This is why communications is a core competency and requires a formal strategy for implementation.

One of the ways the department is working to achieve operational excellence in communications is by organizing the communications function (as defined in this business plan) to distinguish specific competencies and establish targeted resources for marketing, internal communications, and external communications/public affairs. Part of this effort would be to increase and coordinate efforts between divisions and the Office of Public Affairs to market programs and services to potential recipients. Just as

important is the need to formalize the internal communications function to enable strategic activity rather than ad hoc communications.

An important milestone for NC DHHS is to complete development of the electronic survey tool initiated by the Customer Service Taskforce and train employees in its use. The survey tool will be useful for not only soliciting input about NC DHHS performance, but also for general information gathering that will inform individuals responsible for program development and service delivery.

NC DHHS must also do more to share/consolidate call center resources to improve response and resolution to customer inquiries and improve how complaints are received, analyzed, acted on and resolved. While it usually is desirable to establish many portals of entry to the complex NC DHHS array of programs and services, sometimes these portals can diminish, not enhance, the public's ability to negotiate the bureaucracy.

Communications may also be inhibited by an inability to share information in databases across programs and/or divisions. Oftentimes, information islands are created specifically because users either cannot access needed data that already exists, or finds the available data inadequate for their needs. This dilemma reinforces the need to fully identify information needs across the department and maximize NC DHHS's ownership of information so that it can be shared and accessed by more users.

Buildings and Facilities

Buildings and facilities **refers to the management and use of all physical locations available to the organization, whether owned or leased, in such a way as to facilitate efficient delivery of services.**

The Current Environment

NC DHHS currently occupies over 900 buildings throughout the state, most of which were constructed over a 150 year period between the late 1800s and the 1950s. These include hospitals, schools, rehabilitation centers, offices, and many buildings in the town of Butner. In addition to the many facilities owned by NC DHHS, there are also over 200 leased properties utilized by the department. As the GIS derived map at the end of this section illustrates, NC DHHS has facilities throughout the state, greatly easing citizens' access to the department.

There are many positive things happening with NC DHHS buildings and facilities. A new state of the art psychiatric hospital is under construction in Butner, and funding has been approved for two new replacement hospitals and a combined new facility for the state lab and medical examiner. The planned closing of the Dorothea Dix hospital opens new possibilities for the use of the Dix campus. Also, the department has recognized strong, professional leadership in its Office of Property and Construction that has made improvements in the internal management of facilities.

Key Operational Issues

NC DHHS' old and outdated buildings pose many challenges to facilities management and are the source of frequent complains and requests from divisional staff. The scope of required renovations and repairs exceeds the state's ability to fund adequately. In many cases the buildings have out-dated designs that do not optimally support today's operations. The old buildings also present workplace environment quality issues. A work environment that is aesthetically unpleasant is not optimal for working and doing business and affects morale and public perception.

Additionally, there is much opportunity to improve the effectiveness of facilities utilization and staff location. For example, much of the NC DHHS staff in Raleigh are scattered across the city. The controller's office is in three locations. The Division of Medical Assistance exceeded capacity in its buildings on the Dorothea Dix campus and had to put personnel in another office downtown. Even on the Dorothea Dix campus, personnel are scattered. The Division of Facility Services has personnel in multiple building on the campus. This situation is replicated in other areas of the state. In addition to staff location, there is much opportunity to improve inventory management, as warehousing and storage space could be used much more efficiently through a Just in Time.

A significant challenge faced by the department in managing buildings and facilities is the layered oversight and review imposed by the state, which significantly reduces the department's flexibility and response time. Since funding is dictated down to the project level, it is very difficult to make necessary changes to project plans due to such occurrences as changes in the costs of materials or needed project revisions. Also, even minor changes in the spending plan for COPs (certificates of

participation) used to fund the new Butner hospital have to be reviewed by numerous state agencies. Although OPC has responsibility for managing leases, it has little authority in the leasing process and in determining whether a property will satisfy the needs of the department. Additionally, all leases, regardless of size must be reviewed by the Council of State.

Achieving Operational Excellence in Buildings and Facilities

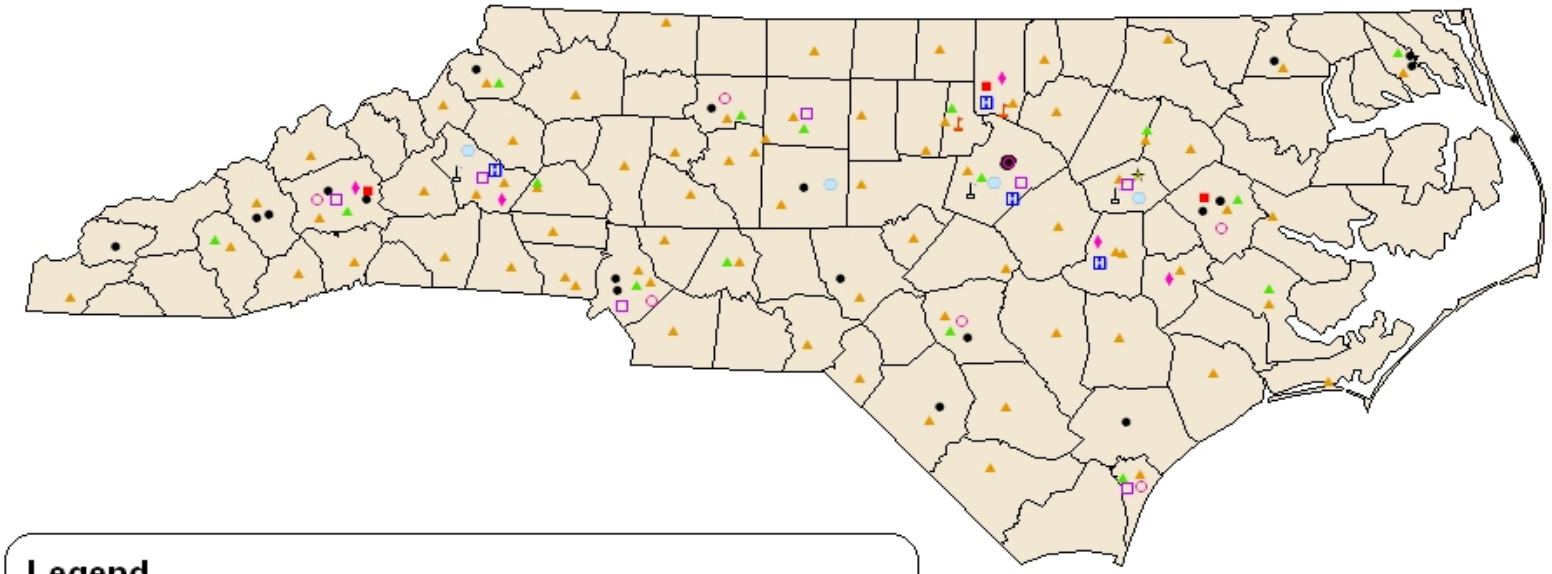
NC DHHS needs more flexibility in decisions about the use of capital funding. Money, time and resources could be saved if, instead of having funding dictated down to the project level, the department had the ability to manage capital budgets in response to changing conditions. The department has been successful in lobbying for revisions to administrative rules that have improved its ability to get construction projects completed in a timely and efficient manner; however more changes are needed.

The scattering of personnel, old and outdated buildings, and lack of optimal co-locating across the state have negative impacts on business operations. One of these is the cost of travel both in terms of time and energy expense. More optimally locating staff would increase worker productivity and the effectiveness of communications. Identifying opportunities to consolidate personnel in common facilities across the state also has the potential to reduce facilities costs, improve the quality of facilities, and improve worker productivity. These issues also have a direct impact on effectively and efficiently managing the IT infrastructure. Given these impacts to operations, the upcoming changes to the Dorothea Dix campus, the department would benefit from an in depth study of facilities utilization from a business functions standpoint.

If the spending plan for Certificate of Participation funds for construction from the Capital Facilities Finance Act is revised even slightly to meet changing needs, such as material costs, the request for the change has to go through Government Operations and Council of State, as well as numerous other state organizations, including State Construction and State Budget. This can add months of delays.

Along with a study on facilities utilization, the department would benefit from a study on how inventory is managed. Automation in the inventory management could greatly improve the efficient utilization of storage and warehouse space as well as the cost of have excessive inventory on hand. Additionally, the ability to utilize geographic information system technology would greatly improve the management, movement of space and be an additional safety factor in responding to emergency situations.

North Carolina Department of Health & Human Services
Division, Program, and Office Locations



Legend

- ADATC
- Blind Services District Offices
- Deaf Services RRC
- EI Programs
- MHDDSAS Centers
- MHDDSAS Schools
- OES Schools
- Psychiatric Hospitals
- Special Center
- Voc Rehab Living Sites
- Voc Rehab Local Offices
- Other Program and Office Sites

Note: Not actual locations, for display only.

State Center for Health Statistics

Part III:

Divisions and Offices Profiles

Executive Management

Current Environment

As the largest, most diverse department in state government, NC DHHS requires a strong and experienced executive management team to establish department goals and priorities, oversee division operations, and interface with decision makers elsewhere in government and the general public. The NC DHHS executive management structure includes the Secretary, Deputy Secretary and two assistant secretaries who meet regularly with their direct reports to coordinate department responsibilities. Also interviewed for this executive management profile were the Special Advisor to the Secretary and a Special Advisor on Workforce and the Director of Government Relations.

Like other departments in North Carolina, NC DHHS has struggled in recent years with inadequate federal and state funding to meet the demands of the state's growing population. In general, big ticket items have been covered, such as homeland security funding for emergency preparedness, NC FAST and MMIS projects, and mental health transformation. Other large projects such as the construction of the new psychiatric hospital in Butner are ongoing, and it is hoped that funding issues will be adequately addressed.

Funding for other operating expenditures has been more problematic and has required management to redirect and reallocate budgeted funds to pay for basic items such as utilities and computers. Other fund sources such as lapsed salaries have been emptied to return monies to the NC general fund, thus reducing NC DHHS's ability to pay for promotional increases, or new positions or other unexpected costs. Since many state employees are already at a competitive pay disadvantage due to several years of little or no salary increases, it is becoming increasingly difficult to recognize, reward, and recruit highly qualified personnel. State employee resentment over wage stagnation is high and inevitably affects performance.

While state office oversight is acknowledged as necessary and appropriate, NC DHHS executive management sometimes struggles with the degree of oversight and the ensuing operational delays. Varied examples relating to IT, OSP, OSBM, and State Construction Office are discussed in other sections of this business plan.

Key Operational Issues

As the NC DHHS organization has evolved, the employee base in the Raleigh area has become widely dispersed. Of the roughly 3,000 state employees in Wake County, about one third are located on the Dorothea Dix Campus, and the remainder are scattered at numerous locations in every corner of the county. This has created unsustainable logistical costs relating to facility leases and maintenance, redundant telephone systems and IT equipment, travel between locations for meetings, and delays in receiving mail and other time sensitive documents. Unquantifiable costs are incurred every day from poor communications and lack of accessibility to people or information. For example, the "centralized" NC DHHS Controller's Office operates out of three separate Raleigh facilities: the Albemarle Building in downtown Raleigh; the Spruill Annex Building on the Dix Campus; and the Oberlin Road facility near Cameron Village.

Closing the Dorothea Dix psychiatric hospital over the next few years represents an opportunity for NC DHHS to review all of its physical location issues and develop a plan for consolidation on

the Dix Campus. While public debate may influence how the Dix property is ultimately used, co-locating many of the NC DHHS operations on the campus is a high priority for NC DHHS.

At times, the size and diversity of NC DHHS works against the department when legislators and other funding sources assume that management can address budget shortfalls in specific areas by reallocating existing funds. To some extent this is possible, but it is increasingly difficult to identify basic operating funds for items such as utilities, facility upkeep, and information systems. Unfortunately, there is great disparity between divisions that have money to invest in the information systems infrastructure and other divisions that have to rely on obtaining obsolete computers discarded from other state agencies when money can be "found". Aside from the obvious productivity and morale issues, this situation increases the cost of maintenance, security, and support.

Executive managers in NC DHHS see a need for more consolidation of the budget function to facilitate consistency and communications. In addition, they believe more emphasis should be placed on acquiring sustainable funding for programs and services rather than expanding services through time limited grants that will require state funds to implement. Part of this emphasis is a need for training to ensure that more employees understand federal guidelines and restrictions, especially since NC DHHS regularly loses expertise through attrition.

In order to better sustain institutional knowledge, NC DHHS has initiated an effort to identify methods to better retain and manage permanent correspondence and transmittals that will serve to document actions, decisions and agreements among the various public and private entities interacting with the department. This will not only preserve information, but will also aid the department when questions are raised about funding decisions. Ideally, both electronic and paper documents would be stored and managed through a central database.

Programmatically, executive management sees the need for new technology to facilitate service delivery, to access information, to allow service providers to handle larger caseloads, and to improve collaboration among divisions in delivering programs and services. Recognizing that the federal government is driving greater collaboration through budget reductions and giving the responsibility to the states to block grant money, NC DHHS will encourage collaboration by keeping the discussion on "how we (divisions and offices) mutually serve clients." This includes embracing a more "client centered" philosophy that focuses on the client (customer) more so than programs, and it includes adoption of an enterprise approach not only in developing technology solutions but in all business applications of the department.

Finally, NC DHHS sees the potential for across-the-board benefits by increasing the focus on preventative measures while maintaining rehabilitative care. According to one executive, "We are in business primarily because of families being in disarray. We need to have dialogues that are not politically correct. For this, we need to support faith based organizations and non-profits at the local level."

Key Indicators for Success

1. More rapid progress moving from solution identification to implementation--especially in instances such as NCFAST where we have the opportunity to establish more collaborative capability among the 100 counties, better enable case management, increase the productivity of county and regional workers, and better serve the public.

2. Explore federal waivers that will increase flexibility in how federal dollars are spent, including waivers for limited services, and better grant management.

3. Improve communications at all levels within NC DHHS and externally with and among the counties, local providers, advocates and residents.

4. Achieve pay equity in the marketplace so that NC DHHS can better compete for the talent needed to advance operational and programmatic excellence.

Programmatic Divisions

Division of Aging and Adult Services

Mission: To promote the independence and enhance the dignity of North Carolina's older adults, persons with disabilities, and their families through a community-based system of opportunities, services, benefits, and protections that offer choice, and to help ready younger generations to enjoy their later years.

Vision: North Carolina's older adults, adults with disabilities, and caregivers will be confident in knowing about and accessing needed supports and services, as well as opportunities for civic engagement.

The Current Environment

In order to support the growing number of aging and disabled adult North Carolinians requiring assistance, DAAS needs to expand the number of home and community-based services and protections and strengthen caregiver supports. Doing so is the priority of the Division of Aging and Adult Services. To accomplish this, the division has three strategic focuses: collaborate more with other divisions and agencies, promote seamless access to services, and become more proactive.

DAAS recognizes that it is necessary to collaborate with other divisions and agencies in efforts to meet the needs of aging and disabled adults. This can be a challenge given the focused nature of funding streams. In addition to participation with the Long Term Services and Supports Cabinet, DAAS has embarked on several initiatives to identify opportunities and to foster collaboration. These include, for example, helping to fund NC Care Link, which is a statewide web-based resource and referral program being implemented by the NC DHHS Office of Citizen Services and DIRM; piloting Aging and Disability Resource Centers in conjunction with the chronic care management activities of DMA, ORDRHD and DPH; and working with DSB, DSDHH, and others to ready our human services workforce for the growing numbers of older adults with special needs. Identifying such opportunities for collaboration will continue to be a focus.

Hand in hand with collaboration is a desire for "no wrong door" for aging and disabled citizens accessing needed services and supports. Seamlessness of access is a problem at the local/county level as well as at the state level. Achieving this will require improved use of technology, improved coordination of funding sources, and promotion of self-directed/consumer-directed care.

To address the challenge of increasing demand and insufficient funds, DAAS is identifying ways of being more proactive in addressing the needs of older and disabled adults and promoting their continued involvement as contributing members of society. The work of its Adult Protective Services Task Force and the support of healthy aging through its Livable and Senior-Friendly Community initiative are examples. One key component of becoming more proactive is having access to relevant data and statistics for planning, development, evaluation, and dissemination of effective practices. It is also a priority of the division to have a greater ability to establish and track performance outcome measures.

Key Operational Issues

To achieve their vision, DAAS has to address some key operating challenges. One of these is the retirement of leaders in their own organization. Possible strategies for addressing this include creating a mentoring process for key positions, supporting the NC DHHS Leadership initiative, and strengthening the recruitment and training of professionals in the field of aging and adult services.

To effectively be proactive through data analysis and tracking performance measures and to be effective at collaborating and promoting the "no wrong door" approach, the division must have more seamless access to and involvement in various systems and data within the department. Since these resources often reside outside of DAAS, it can be challenging at times to access them. It can also be a challenge for the division to get involved with large department-wide IT initiatives, such as NC Leads because DAAS's stake in such systems isn't always immediately recognized and its available funds to help support such ventures is limited.

Another component of being proactive is seeking ways to sustain initiatives proven to be very effective that are originally funded by short term grants. For example, Project C.A.R.E. is a demonstration project that is proving very effective at delaying the placement of persons with Alzheimer's disease or other dementia into institutions. However, it is funded by a three year grant. Unless additional funds are identified, it will not continue. The work with developing Aging and Disability Resource Centers presents a similar concern.

Key Indicators for Success

DAAS has launched the nation's first collaborative effort to train law enforcement personnel for responding to crimes reported against residents of long term care facilities as part of the new S.A.F.E. program (Strategic Alliances for Elders in long-term care). The goal is to build collaborative partnerships with law enforcement agencies at the state level that will improve the community's understanding and response to crimes committed against residents of long term care facilities. Success of this new program will initially be measured by:

1. The number of police officers trained
2. The number of police officers who indicate by way of evaluation that the training was helpful to them

NOTE: This program is in its infancy stages with initial trainings conducted in April, May, and June of 2006. Performance indicators will be updated as feedback from the training is received.

1. DAAS will continue to support the work of the County Boards of Commissioners in their efforts to recruit, train, and retain Long Term Care Ombudsman volunteers. Success will be measured by:

    a. The number of volunteers (NOTE: North Carolina has the nations' second largest number of volunteers – 1,163 as of FY 2004, more than 13% of the national total)
    b. The number of hours contributed by volunteers in their work

2. DAAS will increase the capacity of communities to provide support to family and friends to continue care giving for older adults at home. Success will be measured by:

   a. The number of caregivers served (target is to increase by 2% annually)
   b. The percentage of caregivers served who are caring for someone with dementia
   c. The percentage of caregivers indicating that services 'helped a lot' in making them a better caregiver
   d. The percentage of caregivers indicating that services 'definitely' enable them to provide care longer
   e. Leveraged funds (goal is to grow leveraged funds by 2% annually)
   f. The number of counties participating and the number of people served by the Special Assistance In-Home Program.

3. DAAS will support and develop through funding and certification senior center programming and general operations. Success will be measured by:

   a. The number of senior centers in operation or under development
   b. The percentage of senior centers certified as either centers of "excellence" or "merit"
   c. The number of senior center managers who have received certificates for completing the Ann Johnson Institute for Senior Center Management's 90-hour curriculum.

4. DAAS will help older and disabled adults to remain in their homes and communities. Success will be measured by:

   a. The number of counties participating and the number of people served by the Special Assistance In-Home Program
   b. The number of clients receiving in-home services
   c. The number of clients receiving home-delivered meals assessed as being at risk of institutionalization.

Division of Child Development

Mission: Promote and support high quality early care and education to build a stronger social and economic future for North Carolina.

Vision: DCD will lead the nation, providing a stellar start for NC's children.

The Current Environment

DCD's vision of the future includes an array of strategies to encourage more outcome-based programs for children and coordination of a seamless early childhood education community throughout the state. National studies indicate that early parental involvement and effective learning activities are strong indicators of success for children as they progress through elementary, middle, and high school.

DCD is already recognized nationally for its star rated license system that ranks child care centers and family child care homes on a 1-5 star scale based on program standards and staff education. This innovative program has provided incentives for raising the quality of child care through educational certification of staff and equivalency exams, as well as examination and improvement of the classroom environment for preschool children. DCD continually assesses the rating system to ensure that the results are an accurate reflection of the quality of child care programs.

Key Operational Issues

DCD is challenged by inadequate funding to meet necessary demands for services and programs. The demand for subsidies increases along with the increase in low income families; while at the same time, the cost of care is rising due to increased public/parental expectations for higher quality care. One way that DCD is addressing these financial challenges is by seeking funds through the economic development and business and financing communities rather than only through parent fees and state subsidies. In addition, DCD is increasingly outcome focused and attempts to achieve the greatest return for all its expenditures. For example, DCD offers specific guidance to counties by requiring subsidy business plans to be submitted and by establishing compliance ratings for counties.

Technology plays a major role in the success of the division. DCD field staff improve their effectiveness and efficiency through better use of electronic data; therefore, initiatives are underway to improve the overall IT environment, including mobile access. Enhancements to internal database systems will enable DCD sections to work more seamlessly to track and promote provider education—which in turn will contribute to maintaining or increasing rated license scores. DCD has also made extensive use of teleconferencing to communicate issues quickly and consistently across the state.

An expanding population in North Carolina affects child care in numerous ways: Beyond more staffing to address sheer numbers, there is a need for more bilingual teachers as well as teachers who are trained to care for special needs children who were unable in prior years to participate in group care. To help providers cope with larger and more diverse child populations, DCD will continue to seek expansion funding for staff increases and training, and will explore other options for applying advanced technologies to maximize staff resources.

Key Indicators for Success

1. By 2008, NC will achieve a 10% increase in child care centers earning a score of three or higher in both program and education licensing standards.

2. By 2008, DCD will serve an additional 5% of the (2006) eligible unserved subsidized child care population.

3. By 2008, DCD will better protect children by increasing the number of child care monitoring visits performed by regulatory consultants by 65% annually.

4. By 2008, the statewide average of county subsidy compliance scores will be 95%.

Division of Facility Services

Mission: The Division of Facility Services (DFS) regulates medical, mental health and group care facilities, emergency medical services, and local jails. DFS improves the health, safety, and well being of individuals through effective regulatory and remedial activities including appropriate consultation and training opportunities and the rational allocation of needed facilities and services.

Vision: DFS regulatory work promotes the development and safe provision of health care services and is conducted in a fair, professional, and competent manner.

The Current Environment

The DFS provides regulatory oversight for the state's many health related facilities and institutions including but not limited to plan reviews for facility construction, licensure and certification, and maintaining a health care personnel registry of training and competency for healthcare personnel. DFS actively inspects nursing homes, hospitals, mental health facilities, adult care facilities, ambulatory surgical centers, home health agencies, hospices, clinical laboratories, renal dialysis centers, rural health clinics and a number of other programs, ensuring that providers are following state and, where applicable, federal standards. DFS is chartered to enforce federal and state regulations regarding licensure and certification of certain healthcare facilities. Although improvement of quality of care is of concern, it has remained secondary to the regulatory role.

The majority of DFS employees are nurses, social workers, and other medically trained individuals such as pharmacists and dietitians, most of whom support the inspection processes. In addition to the medically trained personnel, DFS employs engineering and administrative talent, a number of employees who certify and train Emergency Medical Services (EMS) personnel, administer the Certificate of Need program, and inspect county, municipal, and regional jails throughout North Carolina (NC).

Major categories of healthcare facilities in NC have distinctly different histories and regulatory environments. Adult care homes, licensed by the state as assisted living facilities and referred to historically as "county homes" are inspected and regulated at the county level during the year and by DFS on an annual basis beginning in July 2007. DFS holds licensing authority and becomes involved with these facilities during annual surveys, when licensure issues arise, when complaints are filed against healthcare workers, or upon request of the county. Nursing homes and mental health facilities are licensed and inspected according to federal and state standards.

The division's work load has increased dramatically in recent years, due both to population increases and aging and government actions that stimulate new facilities and services without a commensurate increase in DFS resources. A recent example occurred when HB 1060 opened a window of opportunity for the creation of new endoscopy centers. DFS is struggling to handle the influx of plans, creating a backlog in the approval cycle.

In addition, de-institutionalization of mental health services into community settings will have an impact on DFS as adult care homes and mental health facilities deal with the transfer, discharge, and influx of new residents, and as new care facilities are established in local communities.

Key Operational Issues

DFS operates in an environment where there are competing interests on all sides, from CMS and federal guidelines, to providers, patients, and advocates. Balancing all of these interests while fulfilling a regulatory mandate is a difficult proposition. DFS would like to establish quality improvement programs (QIPs) in all licensed facilities / agencies, have staff to monitor the QIPs routinely with the ability to quickly identify and correct compliance problems prior to the occurrence of adverse events and prior to major regulatory action. For the most part, this desire remains an ideal since, as a regulatory agency, determining compliance will always be the first DFS priority and DFS does not currently have the resources for conducting extensive QIPs.

Because regulation is usually understood to define minimum standards of care, DFS recognizes that any definition of *quality* in regulated facilities has to mean more than an absence of citations. As a result, the division has attempted to distinguish the quality and regulatory roles by offering separate training and consultation to facility personnel and county inspectors / social workers. This work is necessarily limited due to shortages of qualified personnel and the necessity for state inspectors to concentrate on regulation and compliance.

As of this writing, nearly 10 percent of the 260 facility survey consultant positions in the division are unfilled. DFS has been successful in raising some salaries for nurse inspectors, but it remains affected by overall market conditions where the shortage of qualified candidates drives up costs and competition. Besides nurse inspectors, DFS struggles to address other personnel shortages, in particular architecture and engineering positions within the construction section. Non-competitive salaries and pay structures contribute to the difficulty in attracting and retaining experienced professionals for facility regulatory oversight of physical plant and life safety systems and operations in licensed and certified facilities. Limited staff is struggling with large backlogs of facility plans that require review in order for construction to move forward.

The division has been working with the Office of Long Term Care (LTC) to create a career ladder for unlicensed health care workers to address recruitment and retention issues in facilities and agencies. This initiative is referred to as the Win-A-Step-Up Program. In addition, DFS has also been working with the LTC office in the development of better jobs/better care initiatives that will offer provider incentives for internal improvements to the management of the care of their clients aimed at improving overall care.

The division is considering a name change to the Division of Health Services Oversight to convey better its role in helping to improve the quality and delivery of healthcare through regulatory review and consultative practices.

More and better use of technology will be a major factor in DFS's ability to maintain and improve its performance in response to growing demands for services. Much of the DFS systems environment is mandated by use of federal databases such as the Automated Survey Processing Environment (ASPEN). This system is used by DFS to track all deficiencies initially cited by nursing home surveyors. While DFS does not have authority to make changes to federal systems, investments are needed to upgrade state and local systems. Most of these systems, such as the Master Facility File (MFF) that is heavily used by DFS, are old legacy systems that are no longer supported by software vendors. The only technical support capability for many of them resides with a few DIRM employees or individuals contracted by DIRM.

An example of where the MFF is used and where new technology would have a dramatic impact is in the annual license renewal process. Currently, the process is labor intensive and takes months to complete. A thick packet containing information printed from the MFF is mailed across the state to thousands of facilities, which are asked to verify that the information is correct. These forms are returned to DFS where a temporary employee hired for roughly three months enters changed or new data into the system. Final documents are then printed and licenses mailed out. This whole process could be tremendously simplified and cost reduced by enabling the licensure information to be updated via secure internet access – rather standardized procedures for thousands of web site applications everywhere. It was hoped that this type of technology improvement, along with the risks posed by old legacy systems, could be addressed through the MMIS project contracted by ACS. With cancellation of that contract, work has ceased. Considering the uncertainties surrounding DFS's involvement with any new version of MMIS in the future, it is critical for DFS and the department to establish a strategy to eliminate or mitigate risks posed by these legacy systems.

More immediate opportunities exist for DFS to make better use of laptop and tablet computers to improve and streamline the inspection process so that information can be recorded directly instead of being transcribed from handwritten notes. Laptops would also give instant access to regulatory language and other information that would be of value in documenting surveys and investigations. Such an approach is being piloted in the federally funded programs.

Key Indicators for Success

OBJECTIVE

License and certify providers for participation in Medicare/Medicaid programs, where applicable, and monitor compliance with minimum standards pursuant to N.C. General Statutes, Administrative Code, and applicable Medicare (federal) regulations

Performance Indicator

As required by law, all adult care home, nursing home, home care, hospice, mental health, hospital, ambulatory surgery, abortion clinic, cardiac rehabilitation, screening mammography licenses and certificates will be issued in accordance with applicable licensing statutes and rules. Monitoring of aforementioned providers will be performed as required in accordance with licensing statues, rules and federal guidelines as noted below:

1. By the end of 2008, all adult care homes and 24-hour mental health facilities will receive annual inspections.
2. By 2008, all home care agencies will be inspected on a cycle of every three (3) years.
3. By 2008, abortion clinics will be inspected on a cycle of once every two (2) years.
4. All nursing homes and intermediate care facilities for the mentally retarded will receive annual inspections.
5. All hospices will receive an inspection every six (6) years.
6. All dialysis facilities will receive an inspection every three (3) years.
7. All jail and detention facilities will receive inspections twice yearly.
8. All plans submitted to the agency for new construction or renovations will be reviewed within six (6) months of receipt.

OBJECTIVE
Credential, license and provide regulatory oversight for emergency medical services and providers in accordance with N.C. General Statutes and Administrative Code.

Performance Indicator

As required by law, all emergency medical service providers and services will be credentialed and licensed in accordance with N.C. General Statutes and Administrative Code.

1. Credentials will be issued for EMS personnel and be renewed every four (4) years.
2. EMS services will be licensed and be renewed every six (6) years.
3. Permits will be issued for EMS vehicles.
4. Trauma Centers will be designated based on a complete application and site visit by trauma specialists coordinated by the Office of EMS. The initial designation period is three (3) years and the redesignation period is four years from the previous designation expiration date.

OBJECTIVE
Administer the Certificate of Need law in accordance with N.C. General Statutes and Administrative Code

Performance Indicator

As required by law, all certificates of need decisions will be determined in accordance with N.C. General Statutes and Administrative Code.

OBJECTIVE
Compile and publish, in collaboration with the N.C. State Health Coordinating Council, the annual State Medical Facilities Plan in accordance with N.C. General Statutes

Performance Indicator

As required by law, the N.C. State Medical Facilities Plan will be published annually and signed by the governor.

Division of Medical Assistance

Mission: To provide access to medically necessary health care services to eligible NC residents so they can obtain high value, high quality health care services resulting ultimately in improved quality of life.

Vision: The Division of Medical Assistance (DMA) will efficiently manage Medicaid and NC Health Choice for Children so that cost-effective health care services are available to all eligible persons across the state.

The Current Environment

The DMA manages the Medicaid and NC Health Choice for Children programs for the state of NC. Medicaid is a health insurance program for certain low-income and needy people and is funded with federal, state, and county dollars. It covers more than 1.5 million people in NC, including children, the aged, blind and/or disabled, and people who are eligible to receive federally assisted income maintenance payments (i.e., WorkFirst, State/County Special Assistance, etc.). NC Health Choice for Children is for children of families who make too much money to qualify for Medicaid but too little to afford rising health insurance premiums. These families are able to get free or reduced price comprehensive health care for their children. The plan, "*NC Health Choice for Children*," is the same as coverage provided for the children of state employees and teachers, plus vision, hearing, and dental benefits.

Although not a perfect comparison, DMA's budget—almost $10 billion dollars—is considerably larger than that of Blue Cross/Blue Shield (BC/BS) of NC. BC/BS covers slightly more individuals, but DMA operates with about 75% fewer employees with the responsibility for review and implementation of all federal and state Medicaid mandates. All but a small fraction of DMA's budget is passed through to Medicaid providers, so the actual operational and administrative support funds to keep DMA running are relatively small. Of a total budget of $9.6 billion dollars, only 2% is reserved for operating expenses at the state level.

All state Medicaid programs are susceptible to any (downward or upward) change in the national, state, or local economy. Equally significant factors that could affect DMA's ability to provide programs and services include:

- Rising cost of health care and malpractice insurance
- Major industry closings and layoffs
- Natural disasters
- Natural aging of our existing population—including in-migration of retirees
- The growing number of immigrants and seasonal/migrant workers in NC
- Policy decisions at the state and federal level that expand Medicaid coverage categories as well as the eligible population

While the growth in the Medicaid budget appears to be slowing, it is still outpacing the availability of new state dollars each year. This is especially true at the county level of government where recent steps have been taken in the state legislature to reduce the burden by substituting state funds for a portion of the county obligation. NC is the only state requiring county funding of Medicaid services.

Furthermore, trends at the federal level threaten to increase the financial burden of each state funding its Medicaid program, and could shift the proportions of health care costs borne by consumers, as well as negatively influence the health care workforce. Specifically, two components of Medicaid involving federal reimbursements, disproportionate share hospital (DSH) payments and upper payment limit (UPL) arrangements, have been reduced by billions of dollars in recent years. As a result, all states are bearing a greater share of total Medicaid expenses.

Other challenges faced by the division include:

- Growth in NC's aged, blind and disabled population—and population growth in general among Medicaid eligibles—has increased the demand for Medicaid funded services.

- Rising cost of prescription drugs—not only is demand increasing, but also the per unit costs covered by Medicaid continue to grow.

- Provider concerns regarding inadequate reimbursement rates—amounts approved for reimbursement have not been sufficient to enroll enough providers in certain groups, most notably dentists. A rate freeze for all of SFY 2005-06 and one-half of 2006-07 could exacerbate this and access to case issues. This is true even though NC Medicaid reimburses physicians (who represent just under one-half of all enrolled providers) at the highest rate in the southeast and 9th highest in the nation.[1]

Key Operational Issues

It is clear to all concerned that the historical rate of growth in NC's Medicaid program is unsustainable. Expenditures increased by double digits in SFY04 (12.3%) and SFY05 (11.3%) and now approaching $10 billion dollars per year. This trend was broken in SFY06 as the increase was held to only 3.89 percent. This reduced rate of increase is among the best compared with the performance of many other states that have reported slower growth or actual declines in expenditures in their most recent fiscal year.

DMA has adopted a number of programmatic approaches to contain costs. Community care networks (CCNC) across the state enhance the ability of health care providers to manage the Medicaid eligible population. In many cases, the CCNC approach provides a connection

[1] Website of the North Carolina Medical Society, http://www.ncmedsoc.org

to a primary care provider where services can be performed, thus diverting individuals from the more costly emergency room visits. As a result, the state will achieve more efficient use of Medicaid funds through better disease management, avoidance of wasteful utilization, and through cooperative efforts with our various providers. To expand and guide these networks, DMA requires more qualified staff to perform data collection, assessment, outreach, and other support work. Skills are needed in areas such as quality assurance, epidemiology, statistics, and a myriad of health care specialties. Significantly, DMA has been a leader in performance based contracting and has established one of the finest contract offices in the department – a crucial competency for a division that administers nearly 100 contracts valued at $125 million.

DMA is also adopting new policies that will reduce the state's share of prescription drug costs by shifting some costs by encouraging physicians to prescribe more generics, targeting recipients with multiple prescription drugs for clinical review, and "locking-in" others to a specific pharmacy. Notably, NC is one of only four states to receive a clean audit of its drug rebate program whereby pharmaceutical companies pay rebates to the state in order to have drugs covered by Medicaid. In NC, these rebates totaled $370 million in SFY 2005.

The success of these and other initiatives, such as DMA's involvement with state mental health transformation, requires a substantial amount of information flow from and to other divisions and external entities. For approximately 30 years, the state has had the same vendor supporting the Medicaid claims processing system and associated outsourced business functions. This system serves over 60,000 providers and processes over 80 million Medicaid claims totaling about $6 billion annually for health services and 3.4 million other claims totaling $225 million. Basic functions such as provider enrollment, eligibility determination, reimbursements, and program integrity (where over $1.1 billion was saved, recovered, or cost avoided in SFY 2006) influence spending and service delivery throughout the system. The legacy MMIS architecture is outdated and requires significant maintenance to implement most mandated business rules. System limitations inhibit the division's ability to set up efficient reimbursement practices and detect spending or treatment patterns. Furthermore, important changes to the system are difficult due to the complexity of patched legacy systems (such as recoupment and repayment processes) which are becoming so old that vendors have begun discontinuing technical support. This creates situations where many of the desired modifications are obsolete by the time they are implemented, if implemented at all.

In 2004, NC DHHS contracted with a new vendor for a new MMIS+ that would incorporate all functions related to claims processing, provider enrollment and credentialing, along with a variety of advanced features for tracking, web access, and voice response systems. The divisions of Public Health, Mental Health, and Facility Services were all a part of this multi-payer system. This development contract was recently terminated; nonetheless, the state and CMS are still seeking to replace the legacy MMIS+ with new technology that will maximize efficiencies, improve flexibility and reduce operating expenditures.

Because administrative operations are very lean, expertise is lacking in certain needed areas within the division - notably clinical policy, financial management and fraud and abuse activities. In some instances, a single individual holds all the history in a given area. There simply are no backups and no one available to be trained. In other situations, staffing has not kept up with growth in Medicaid programs and providers. For example, 10 years ago it may have been practical to have one individual working on transplant and out-of-state hospitalization issues. Today, two or three individuals are required to handle the demand. DMA has one transplant nurse who works, or is on call, every day from 5:00 am to 1:00 pm. In another example, five

years ago it might have been feasible to assign one or two auditors to monitor mental health providers. The explosive growth in the number of these providers (over 5,000 were added in 2005) now demands a minimum of six to eight auditors, plus a supervisor. Similar examples can be found throughout DMA's administratively thin organization.

Staff shortages also inhibit the division's ability to deal effectively with turnover in key positions, internal promotion, and even normal employee absenteeism. In addition, subject matter experts within DMA are in high demand throughout NC DHHS since Medicaid touches so many of the department's services. While both government and the private sector present many novel ideas or exciting therapeutic options, implementation is either too slow or impossible due to resource limitations. To address some of these limitations, DMA has been forced to increase its contractor workforce, ironically (at times) at a higher cost than if full-time state positions were approved.

The future success and sustainability of the Medicaid program will require numerous changes: Continuing to maintain budgetary control; shifting from being regulators to managers of health care; improving the quality of care provided (which includes an increased focus on "best practices," prevention and disease management); evaluating the current system of provider reimbursement in terms of pay for performance; integrating/supporting the use of Electronic Health Records (EHR) and continuing efforts to transition institutional services to community settings. While all agree these are critical initiatives and solutions are complicated, staffing and funding to address them have not been forthcoming.

Inadequate staffing and funding restrictions are the main inhibitors to continual improvement in DMA's performance. Management recognizes that state funding will not support the human resource needs of the division (a request for an additional 43 people were omitted by OSBM for inclusion in the Governor's budget), not to mention funding requests for improving the Information Technology (IT) infrastructure. At the same time, management also recognizes that the division must continue to strive for flexibility, innovation, and continual improvement to sustain the Medicaid program.

Operational benefits to making these changes will be improved efficiency, more timely assessments of health and eligibility, and the ability to address more of the innovative projects that are presented to the agency. For this reason, DMA advocates a slow shift in funding priorities that increases the emphasis on prevention and early detection of health problems. The public would benefit from better health outcomes, faster access to the best available diagnostics and therapeutics, and better customer service. The state would benefit from a healthier, and thus less costly, population.

Key Indicators for Success

1. Budgetary Control

DMA will successfully reduce costs and exceed our budgetary targets each year.

2. Management Rather Than Regulation

DMA will establish a culture of proactive healthcare management rather than a pure regulatory function for the division.

3. Quality Improvement

DMA will improve the care provided to Medicaid patients by reducing variability and promoting best practice standards by utilizing and expanding CCNC.

4. Accountability

DMA will establish a culture of accountability within the agency and with provider groups by benchmarking and measuring all key services. We will aggressively eliminate unnecessary utilization of services and fraud.

5. Customer Service

DMA will define those that we serve and strive to meet or exceed agreed upon expectations.

6. Public Image

DMA will improve the public image of the division and the Medicaid program.

7. Job Satisfaction

DMA will make the division a great place to work and find ways to reward our colleagues.

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Mission: North Carolina (NC) will provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment services, and supports they need to live successfully in communities of their choice.

Vision: NC residents with mental health, developmental disabilities, and substance abuse service needs will have prompt access to evidence-based, culturally competent services in their communities to support them in achieving their goals in life.

The Current Environment

The Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) is the largest division in NC DHHS with over 12,000 employees working throughout the state at its headquarters in Raleigh, four large psychiatric hospitals, four developmental disabilities centers, three alcohol and drug abuse treatment centers (ADATCs), two residential programs for children, and two special care centers which offer specialized services for individuals with Alzheimer's Disease and other individuals who were previously served in other division facilities and whom cannot be placed in traditional nursing care locations. As the NC population continues to grow, so too does the need to provide for an increasing number and diverse group of residents who require significant medical and behavioral support.

In 2001 the North Carolina General Assembly enacted sweeping legislation to reform the public mental health, developmental disabilities and substance abuse services system. The legislation fundamentally altered the role of the division and the area authorities-- entities of local government that at the time of the enactment of the legislation functioned as the primary providers of services outside of state institutions. The legislation sought to increase accountability in the system by separating service delivery from management oversight, to improve consumer's access to services, and to increase consumer and family participation in the management of the service delivery system. To accomplish these goals, the legislation required area authorities, now known as Local Management Entities or LMEs, to change their focus from service delivery to system management and to develop an alternative array of private providers to deliver services. In order to increase efficiency and gain economies of scale, it also targeted a reduction in the number of LMEs to no more than 20 by 2007. The legislation also required a reorganization of the division, which was accomplished in 2003. The effort to transform the mental health system in NC has had a profound impact on the way DMH/DD/SAS operates, both internally throughout NC DHHS and externally with LMEs, providers, partners, and recipients of services. The skill sets needed to manage the system at the state and local level are significantly different from those required in the old system. With the growth of the private provider community, the need for standardization of functions, processes, and products and the need for automated, electronic means of sharing information have increased exponentially.

The reform legislation and the U. S. Supreme Court's ruling in the case of Olmstead vs. L.C. are also having a profound impact on the state facilities. The legislation and the Supreme Court

decision emphasize the preference that mental health, developmental disabilities, and substance abuse services are delivered in community settings, rather than in large institutions. There will continue to be a need for state facilities, but their role and the populations they serve are changing. A clear example of that is the change currently being implemented in the state-operated Alcohol and Drug Abuse Treatment Centers (ADATCs). Providers have been successful in increasing capacity in community-based substance abuse rehabilitation programs, but they have not been successful in developing community-based detoxification services, particularly for individuals with significant medical complications. In recognition of that reality, the model for the ADATCs is being changed from 28-day rehabilitation facilities, to providers of acute and sub-acute detox services for particularly challenging individuals.

Some of the division's aging facilities require renovation so extensive that they will be rebuilt in their entirety. The new hospital under construction in Butner will replace two of these aging psychiatric hospitals: Dorothea Dix in Raleigh and John Umstead in Butner. The General Assembly recently approved special indebtedness funding to replace the other two hospitals in Goldsboro and Morganton before the end of this decade.

In helping to transform the MH/DD/SAS environment in NC, the division is leading the effort to assist LMEs to evolve from their traditional role as direct service providers to managers of community services with the following responsibilities:

- Developing local business plans and strategic planning, including ensuring that consumers and family members and other community partners are engaged in planning and implementation
- Ensuring prompt access to services through 24/7/365 screening, triage and referral functions
- Building service capacity through provider development efforts
- Collecting data and evaluating outcomes to address gaps in services, the quality of services, and the effectiveness of providers
- Providing care management to ensure coordination of services for high-need consumers

Accomplishing these objectives requires division employees to expand and enhance their own core business skills as adjuncts to the traditional programmatic areas of expertise. Performance based contracts have been developed and are evolving to document and measure each LME's success in implementing the new responsibilities. The number of LMEs has decreased by ten, but the Division continues to encourage LMEs to identify ways to achieve greater efficiency and economies of scale. Many LMEs have completely divested of service provision, and others continue to deliver only a small handful of services. However, it is likely that some smaller number will retain a fairly significant role as a service provider for some time to come.

Internally, DMH/DD/SAS is dealing with many of the same challenges faced by other NC DHHS divisions. A fundamental inability to recruit, retain, and adequately reward employees has left the division with a shortage of operational and programmatic expertise at all levels. Where current employees are near retirement (which is the case with virtually all of the senior staff in the central office and in the institutions) the division has been unable to put together an adequate succession plan due to state requirements concerning non-competitive pay grades, classifications, salaries, and reward systems. The result is that the division struggles to compete in the marketplace for the best and brightest.

Key Operational Issues

The Office of State Budget and Management projects a 7.5% population growth (651,000+) for North Carolina from 2005 to 2010. This means that the number of people seeking MH/DD/SAS services will continue to grow and will stress human and financial resources. Ideally, DMH/DD/SAS endorses a policy of budgetary increases based on population growth and inflationary increases, especially at the community level (similar to how public school funding is viewed). Continued productivity and patient care is jeopardized by chronic under funding of operations that has resulted in aging equipment, a lack of preventative maintenance, and underutilization of technology in both facilities and division offices. A striking example of this is that DMH/DD/SAS institution employees are working with obsolete, hand-me-down computers discarded by another state department. Division employees struggle daily to provide services to NC consumers with old computers considered unusable by other state departments.

A more egregious example of the inability to address current industry standards in technology is apparent in the problems the division's institutions are facing in complying with the new Medicare Prospective Payment System for psychiatric hospitals and new Medicare Part D prescription drug billing protocols. The General Assembly approved the issuance of $20M in special indebtedness to begin to develop the necessary technology for the new hospital being built in Butner, but funding will not be sufficient to complete the project, let alone implement the new system in the other division facilities.

Financial investment in technology is required to address other issues such as:

- The state institutions currently do not have systems that most inpatient facilities find critical to ensuring quality clinical care by having real-time access to clinical information at the point-of-care. The only place that consumer data on ancillary services is compiled for consumers served in DMH/DD/SAS state facilities is in paper medical records.
- Inability of the division, LMEs and providers to communicate and transfer patient information effectively due to outdated information technology and information systems. No standard data system is in use at the LMEs, and the electronic medical records that some LMEs have developed independently do not interface with other LMEs or with the state facilities. The inability to communicate seamlessly regarding "shared" consumers exacerbates the problem of a lack of integration between state facilities and community services.
- Sharing of information/data on consumers being served by multiple public agencies to coordinate services and funding more efficiently. Some states are developing systems that allow a provider of service to submit a combined bill to the state for all services rendered and the state's payment system identifies the specific "pots" of money that can pay for each service. NC is far away from being able to do this since there is no way of knowing at the state level which consumers are receiving services from multiple agencies.
- Inefficient, labor-intensive work systems that rely on manual and paper processes.

These problems can only be solved by investing in modern information systems, clinical care and client management systems and billing systems, new tele-medicine technologies, and then integrating these systems to improve consumer outcomes, information sharing, and revenue recovery. DMH/DD/SAS has requested additional funding for computer hardware and software and replacement or upgrade of automation and clinical care and client management systems in

state facilities. These investments would allow DMH/DD/SAS to participate more fully in the national movement to electronic medical records, documentation, and electronic billing.

The division was a partner in NC DHHS's efforts to secure a new Health Information System (HIS). HIS will provide a means for capturing, monitoring, reporting and billing services provided in local health departments, Child Development Service Agencies and the State Laboratory of Public Health. While HIS is not a solution for state facilities operated by DMH/DD/SAS, it could largely solve the information issues faced by LMEs and the local community providers. However, the decision has now been made that DMH/DD/SAS will not continue to be involved in this effort at this time. Since 75% of the LMEs use the software vendor that has been chosen as the platform for HIS, the division is still hopeful that this project may eventually be beneficial to LMEs and the division.

Lack of understanding of the complexity of the undertaking of transformation of the entire system and how long it would take to implement the required changes has caused some support to waiver. To the extent that the unique needs of the MH/DD/SAS community are understood, that support will increase. Some of the communications priorities listed by DMH/DD/SAS leadership are:

- Restructuring a web site that traditionally targeted the LMEs but must become more consumer and provider friendly.
- The division collects many data in the quality management section, but reports are too detailed and are not understood well by important constituencies. This information must be simplified so that decisions, actions, and priorities are better understood by all.

Other forms of outreach will be explored to better articulate the MH/DD/SAS vision to the public.

In some cases, better management practices have been identified that address funding and resource shortages. For example, the division has placed restrictions on which grants/ demonstration project opportunities can be pursued. This was done for two primary reasons. It was decided that it was not prudent to devote scarce human resources to projects that might be interesting but do not contribute to achieving the core transformation goals of the division. In addition, many of the federal grants obtained in the past established programs that were funded in the short term but required recurring state funding to continue. This often resulted in a lack of sustainability. By reducing the numbers of grants and demonstrations pursued, the division is better able to guarantee the continued success of ensuing programs and services.

Performance based measurement is being applied to all contracts, not just those formed with the local management entities. The contract process—including how contracts are organized in the division—also represents opportunity for cost savings by improving contract language and speeding up approvals. This and other administrative processes are being reviewed to reduce the unnecessary layers of management review within the division, within the department, and from other areas of state government, and ensure that each working step represents value added to achieving the end objective.

Despite the great need for investments in facilities and technology, by far the most important key to success in DMH/DD/SAS is the ability to invest in people. Success in implementing reform of the MH/DD/SAS system depends on leadership and support at the executive and legislative levels of government. An important measure of this support is the recognition that highly trained, highly motivated people are needed to devise, administer, and deliver critical services. Creative solutions are needed so that the division can become more competitive in the marketplace for

professionals who are hard to recruit and retain. In many cases, the personnel system places nearly all job value on clinical skills and education. As job requirements evolve in the reformed system, so too must the state's personnel system evolve to account for and value non-clinical skills such as business, finance, quality and process improvement, and many of the other competencies that are now essential throughout the workforce.

Finally, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services will continue to obtain commitment at all levels of state, county and local government to fulfill its mission and promise to "…*provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice."*

Key Indicators for Success

1. To increase provider capacity and service availability across the state in an equitable manner in order to meet the needs of consumers.

   Strategy 1.1. To develop a long range plan to determine service needs, service availability and gaps in service.

   Strategy 1.2. To facilitate the recruitment and enrollment of qualified providers.

2. To provide greater standardization of management and service delivery at all levels to ensure consistency and quality of practices, including screening / triage / referral, person-centered planning, local management entity (LME) and provider oversight, and data requirements.

3. To establish a statewide utilization review process for state-funded services with standardized procedures and formats.

4. To complete the new central regional state psychiatric hospital to replace aging facilities at Dorothea Dix and John Umstead Hospitals.

5. To renovate the first of four (4) units at O'Berry Center and obtain certification as a specialized developmental disabilities nursing facility to meet the growing service demands for this population in the eastern and central regions of the state.

6. To increase capacity to provide 84 acute beds at the ADATCs to divert involuntary substance abuse commitments from state psychiatric hospitals into more appropriate treatment.

7. To develop and implement a culturally competent workforce development plan for the service system that addresses the needs for the service system throughout the state.

8. To develop and implement a recruitment, recognition, and retention plan for the division that informs and involves staff and ensures adequate leadership for the future.

9. To communicate effectively with all stakeholders.

Strategy 9.1. Establish an external advisory group of stakeholder organizations to obtain their guidance and advice on division policy and practices.

Strategy 9.2. Revise the division's public web site to better inform and engage stakeholders and to be user friendly for diverse populations.

Strategy 9.3. Produce an annual report for the division to be communicated to constituents and publicized through the web site.

Division of Public Health

Mission: § 130A-1.1. Mission and essential services. (a) The North Carolina General Assembly (NC GA) recognizes that unified purpose and direction of the public health system is necessary to ensure that all citizens in the state have equal access to essential public health services. The GA declares that the mission of the public health system is to promote and contribute to the highest level of health possible for the people of NC by:

(1) Preventing health risks and disease; (2) Identifying and reducing health risks in the community; (3) Detecting, investigating, and preventing the spread of disease; (4) Promoting healthy lifestyles; (5) Promoting a safe and healthful environment; (6) Promoting the availability and accessibility of quality health care services through the private sector, and (7) Providing quality health care services when not otherwise available.

Vision: To add years of quality life for NC citizens, and to eliminate health disparities.

The Current Environment

One of the important functions of public health, along with disease prevention, reducing health risks, and promoting healthy lifestyles, is providing response in emergencies. Whether natural, man-made, local or statewide, public health must be continually alert and prepared to respond appropriately to the emergency situation. As a result of the anthrax attacks in 2001 and more recent concerns about outbreaks such as pandemic flu, the public has become increasingly aware of the importance of this function. Consequently, more resources have been directed toward strengthening emergency preparedness, incident detection and crises response in the public health system across the nation.

This attention on the role of public health in preparedness has not only enabled the NC Division of Public Health (DPH) to become stronger in preparedness, it has also resulted in the strengthening of the entire public health system. Specific examples are recent significant improvements to the Information Technology (IT) infrastructure as a result of federal bioterrorism funding, which is a core part of public health, plans for a new state lab, and the ability to move forward with initiatives that the division has been trying to advance for many years, such as a controlled substance monitoring database.

To help guide their more visible role, the division created the Public Health Task Force 2004 to strategize public health initiatives in NC. In early 2005, the task force produced the Public Health Improvement Plan and has been successfully executing the plan. This year, DPH is convening the Public Health Task Force 2006 to focus on strategies for eliminating health disparities, strengthening the infrastructure, and filling in service gaps.

Now that preparedness is strengthened, DPH will increasingly focus on linking program efforts to prevention of larger chronic health issues, such as cardio-vascular disease, diabetes, and obesity that are the leading causes of death and high health costs in NC. Examples include prevention activities in chronic disease and coordinated school health initiatives. DPH is working in concert

with the Department of Public Instruction (DPI) and NC DHHS Division of Medical Assistance (DMA) to align resources and policies to leverage their common goals and cross organizational boundaries.

The following trends that impact public health will impact DPH as the division strives to accomplish its vision over the next three to five years:

- A high drop out rate in NC, particularly for African American males;
- Alarming increases in obesity and the associated health risks; and
- Population growth, increasing cultural diversity and language issues (Latino, Hmong and Russian populations), and an aging population.

Key Operational Issues

One of the most important improvements that can be made to the public health system is in the area of information technology. Recognizing this, the federal government, through the Center for Disease Control, is requiring all states to develop a Public Health Information Network (PHIN) that "is both a response to the needs for better integration among public health systems and a plan for developing systems and infrastructure to better support public health activities and improve public health outcomes."[1]

As a result of the focus on preparedness, federal money is being provided to NC to implement many of the systems for PHIN. The information systems being developed will revolutionize service delivery, billing, and patient management. These tools will also provide a new level of client, clinical and epidemiological information not previously available. The new systems are:

- **NC Health Alert Network (NC HAN)**: An internet-based system used that enables communications between key public health officials and their partners about public health emergencies. HAN was implemented in October 2002.
- **NC Electronic Disease Surveillance System (NC EDSS)**: A centralized system for disease reporting that will significantly improve the timeliness, reliability, and accuracy of reportable disease in NC. It will be fully integrated with NC HAN.
- **Vital Records (VR)**: A system that will improve the birth and death registration processes.
- **Laboratory Information Management System (LIMS)**: A system for submitting and reporting lab results electronically that will utilize the HL7 method of messaging and facilitate enhanced processes at the state lab.
- **NC Immunization Registry (NC IR)**: A web based system that provides a consolidated immunization record for every child in NC. NC IR was implemented in June of 2005.
- **Health Information System (HIS)**: A replacement of the outdated Health Services Information System (HSIS). HIS will provide a means for capturing, monitoring, reporting and billing services provided in local health departments, Children's Developmental Services Agencies and the State Laboratory of Public Health.
- **NC Disease Event Tracking and Epidemiological Collection Tool (NC DETECT)**: A tool for enhanced public health surveillance utilizing data from a variety of existing sources.
- **State Agency Model System (SAMS)**: A new system for the Women, Infants, and Children (WIC) program.

[1] http://www.cdc.gov/PHIN/overview.html

- **NC Hospital Emergency Surveillance System (NCHESS)**: A system to electronically collect, report, monitor, and investigate emergency department and hospital data in near real-time.

The next 18 months are critical in the implementation of PHIN since many of these systems are planned to go online by 2008.

As DPH moves ahead with implementing PHIN and all its associated systems, they have some concern that enterprise IT standards and guidelines being developed at NC DHHS, IT services at the state level and by other federal agencies may eventually contradict and delay the advancement and implementation of PHIN. Obviously, efforts to better coordinate IT responsibility and to think from an enterprise point of view are critical, not only to DPH but to the department and state as a whole.

Attracting and retaining a skilled and talented workforce is also essential for a strong public health system. Beginning in 2006, 43% of the department's state public health workforce will be eligible for retirement[1]; nationally, as high as 45% of the public health workforce is eligible for retirement[2]. The department's ability to effectively provide the type of skill and competency training needed to retain the existing public health workforce, as well as recruit and retain an increasingly more diverse and culturally competent public health workforce for the future, is paramount to DPH successfully accomplishing its mission.

DPH is making efforts to strengthen operations and enhance program integration, and is currently undergoing a re-organization that will also better integrate programs and breakdown silos. Some of the key changes in the re-organization are the re-creation of a NC Deputy State Health Director, the creation of a new Preparedness, Medical Examiner, and Laboratory Section, and the creation of a new branch called "preparedness". Additionally, they are strengthening capacity in their purchasing and contracting areas and in the VR. Proposed changes in Medicaid law requiring proper identification and proof of citizenship will present an operational challenge to VR. If this law is passed and improvements are not made to current VR processes, DPH could become a barrier to citizens receiving benefits. Another issue related to VR is the need for improved facilities that provide better parking and adequate protection of the states vital event records. Additionally, Medicaid reimbursement rates are not keeping up with the cost of providing services at the local health departments and the CDSAs (Children's Developmental Services Agencies).

While the division is making efforts to improve operating effectiveness, they still must deal with obstacles and delays within state bureaucracy which impede their ability to take timely actions, deliver services and meet reporting deadlines. DPH fears that such delays can ultimately result in the loss of federal funding.

Key Indicators for Success

DPH Vision Statement: To add years of quality life for NC citizens, and to eliminate health disparities through the following:

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[2] http://www.astho.org/pubs/NursesWorkforce.pdf

1. Addressing Women's and Children's Issues

By 2008:

a. The statewide school nurse to student ratio will be 1:1175 based on the expansion budget request for 100 new school nurse positions in 2006-07 and 250 positions in each of the next four (4) years. DPH is working toward the national goal of 1:750. (Baseline: 2004-05 school year ratio was 1:1593)

b. The universal vaccine program will be 100% funded for all vaccines routinely recommended by the U.S. Advisory Committee on Immunization Practices (ACIP).

c. 20,000 patients (women and men) will be served under the family planning waiver and the number of low income patients (women and men) receiving family planning services by county will increase by 10% in 80 counties. (Baseline year: 2004).

   Note: Low income patients include those persons in need of publicly financed family planning services (i.e., Medicaid, waiver, title X) and served by all providers (public and private) in a county during a calendar year.

d. The early intervention program will meet the goals on its State Performance Improvement Plan associated with enrollment into and transition out of the program and timeliness of service planning and delivery.

e. There will be 450 medical practices actively participating in the "In the Mouth's of Babes" (IMB) dental preventive services, (including fluoride varnish) and providing a total of 400,000 dental preventive services provided cumulative since 2000.

2. Addressing Epidemiological Issues

By 2008:

a. The HIV/STD Prevention and Care Branch will increase the number of persons tested annually by publicly funded test sites for HIV infection by 15%. (Baseline: 120,000 per year).

b. AIDS Drug Assistance Program eligibility will be increased to 250% of the federal poverty level. Current eligibility is 125%, the lowest in the United States (US).

c. 100% of local health departments will have completed and exercised a local All Hazards Response Plans to include the Pandemic Flu Plans.

d. DPH will have initiated construction of new state public health laboratory facilities and a new state medical examiner facility.

3. Preventing and Controlling Obesity and Chronic Disease Issues

By 2008:

a. All NC schools and hospitals will have100% tobacco free campuses for students, patients, staff, and visitors 24 hours/day, seven (7) days/week.

b. NC will have an annual state wide surveillance system for child health indicators.

c. The public and decision-makers will be educated about the public health impact of increasing the cigarette tax by at least 75 cents, or 75% of the national average.

d. 100% of NC school districts will provide 30 minutes of daily physical activity for all students in grades K-8.
(No baseline data currently available).

4. Implementing Accreditation of Health Departments

By 2008:

a. 50% of the local health departments will be accredited.

b. The state DPH will be accredited using a state-established accreditation program.

5. Strengthening New Technology

By 2008:

a. The following IT systems will be fully implemented under the PHIN:

1. NC Electronic Disease Surveillance System (NC EDSS) – part of the national system to electronically report diseases and conditions of public health significance.
2. Vital Records (VR)
3. Laboratory Information Management System (LIMS) – electronic system for submitting and reporting laboratory results.
4. North Carolina Immunization Registry (NCIR) *(NC IR was implemented June of 2005)*
5. Health Information System (HIS)
6. NC Disease Event Tracking and Epidemiological Collection Tool (NC DETECT) – enhanced public health surveillance utilizing data from a variety of existing sources including hospitals, poison control center, emergency medical services, and veterinary medicine.
7. State Agency Model System (SAMS) for Women Infants and Children (WIC) program
8. NC Health Alert Network (NC-HAN) – a secure automated system for alerting public health officials and key partners using e-mail, phone, fax, and pagers. This system has been implemented.

Division of Services for the Deaf and Hard of Hearing

Mission: The Division of Services for the Deaf and the Hard of Hearing (DSDHH) serves individuals who are Deaf, Hard of Hearing or Deaf-Blind, their families, and communities in North Carolina (NC) by enabling them to achieve equal access, effective communication and a better quality of life.

Vision: Every person who is Deaf, Hard of Hearing, or Deaf-Blind in NC has equal access to those communication and human services that are provided to all individuals in the community.

The Current Environment

Through seven regional centers and central staff located in Raleigh, DSDHH provides direct services to individuals, private and public agencies, medical and health care facilities, community organizations, educational institutions, and businesses. These services range from direct assistance and training to access advocacy, counseling, communications and information dissemination, and interpreter skills development.

One out of eight North Carolinians, or just over one million people, experience some degree of hearing loss. By 2030, there will be about 2 ½ million residents with hearing loss, with many more of them experiencing hearing loss at relatively early ages. This rapid growth of the customer base stresses resources at all service levels and has created high demand for staff with specialized knowledge and skills.

In February 2005, NC became the first state in the nation to establish an ongoing, statewide program to distribute hearing aids to eligible low-income NC residents. The division is a national leader in other areas such as marketing and communications, critical for increasing awareness of services and resources among people with hearing loss.

Key Operational Issues

As the population of individuals with hearing loss grows, the need for improved technology will be an increasing factor in core business operations. Systems are needed to track telecommunications and other assistive technology equipment that has been authorized or distributed to customers. Because effective communication access by customers is critical, a process needs to be in place to assure the division's technological resources are kept commensurate and compatible with the technology commonly used by their customers. Effective case management will require information coordination within the division and across NC DHHS divisions such as vocational rehabilitation and services for the blind. Operational efficiencies can be enhanced through better internal coordination with NC DHHS offices such as Budget and Analysis, Human Resources, Property and Construction, and Information Resource Management.

Non-competitive salaries and specialized skill requirements have forced DSDHH to expand out-of-state recruiting and have severely impacted the division's ability to fill critical vacancies. This not only impacts programs and services, but also impacts the capacity of the division to operate efficiently because available resources are frequently diverted to deal with emergencies and other short-term issues. Further, the small size of the division's management hinders its capacity to be consistently responsive to operational demands at all levels.

Staffing shortages impact service agencies as well as state offices so that there is an ongoing struggle at all service levels to maintain an adequate knowledge base from year to year; therefore, training occupies more and more of the resource capacity of the division. This includes supervisory and business management training for managers, interpreter training, training for providers of communications access equipment, customer service and client assessment training, and teaching service providers how to work with individuals with diverse needs.

Key Indicators for Success

By 2008:

The division's media campaign will maintain a 90% penetration of the over-35 NC television markets and a 50% penetration of the over-35 radio markets.

1. The number of clients served per year will increase from 2500 to 3500.
2. The number of agencies served per year will increase from 1400 to 2500.
3. The number of hearing aids (one per individual) distributed per year will increase from 1010 to 3000.
4. The number of individuals served by the division's Telecommunications Equipment Distribution Program (TEDP) will increase from 2000 to 8000.

Division of Services for the Blind

Mission: To enable people who are blind or visually impaired to reach their goals of independence and employment.

Vision: By 2008, DSB will be known across North Carolina as the leader in providing employment and independent living services for people who are blind or visually impaired.

The Current Environment

As DSB strives to be a leader in enabling people who are blind or visually impaired to reach their goals of independence and employment, it is imperative that they focus on a few key areas. As the vision statement indicates, one key item necessary for success is getting the word out to individuals who need the services offered by DSB. It is not uncommon for individuals receiving DSB services to comment that they wish they had known about DSB sooner. These comments are often made by families who have children with significant vision loss who could have benefited from DSB services as the children transitioned from school to other training or employment. Or, from adults who lose their vision and were not aware of the services that the Division could provide to help them develop independent living skills and continue to work. For this reason, a central part of the DSB plan is to market their services, with a particular emphasis on minorities and retirees.

Also central to DSB success is improving employment opportunities for people who are blind or visually impaired. The Division will focus on three areas in order to accomplish this goal: (1) being recognized as the leader in the use of and in having expertise about assistive technology for those with vision loss; (2) broadening relationships with employers; and (3) identifying training that will provide skills that match the needs of the job market and encouraging those served by the Division to pursue training.

Assistive technologies are a critical element in blind and visually impaired North Carolinians being able to work and live independently. These technologies are constantly advancing and changing, which requires DSB staff to keep abreast of technology that is available as well as being experts in the use of the technologies. DSB works closely with vendors to maintain and build expertise.

Formerly DSB appealed to the goodwill of employers to hire blind and visually impaired employees. DSB now positions itself as a source of good employees who can meet the needs of employers. This requires educating and building relationships with employers. Marketing themselves to employers is a key component of their plan.

As the economy of North Carolina changes, the types of jobs available are shifting to more service and professional jobs. This means that DSB must ensure that their vocational rehabilitation specialists are qualified for training people on the skills needed in the current job market. DSB is constantly evaluating its programs, services, and staff knowledge to determine what changes should be made in order to meet the needs of the consumers seeking employment and the business community that we serve.

Key Operational Issues

In order to be successful, DSB faces some challenges to operating effectively. One of these is the ability to recruit and retain qualified rehabilitation and orientation and mobility specialists. This proves challenging for three reasons: (1) the pool of qualified candidates is small; (2) the Rehabilitation Act of 1973, as amended sets a high education standard for people employed in rehabilitation counselor positions; and (3) DSB has a difficult time competing with other employers, particularly private sector agencies, for the limited number of qualified candidates for counselor positions.

Another challenge that the division must address in the near future is that of its mainframe application which serves several purposes including (1) processing of authorizations and invoices paid for services to consumers and (2) tracking data on individual consumers served which is used to generate program reports at the state and federal level. The system has been in place since the early 1990's. Over the last several years the system has been called on to meet more needs with new programs added and more detail needed in the data collected. Because the program is not a web-based one, accessing it from remote locations can be difficult, and accessing the program by those who use adaptive technology is even more difficult. The division will be looking at options for moving to a web-based program that will be written in an "updated" language, will provide greater access and flexibility, and will be capable of meeting both data collection and case management needs.

Another challenge is found in working with other state agencies and departments to ensure that their initiatives which impact on DSB staff or consumers are accessible, particularly when forms or other electronic formats are used. DSB has a number of employees with vision loss who use assistive technology and are very independent in performing all aspects of work within the division when good access is available. However, any initiatives that do not employ accessible formats will create major operational difficulties for the staff which will ultimately have an impact on the consumers served.

Key Indicators for Success

1. By 2008, the average wage of visually impaired individuals who have successfully achieved their employment goals through services received from the North Carolina Division of Services for the Blind will increase by fifteen percent.

   Strategies:
   - Jobs not previously open to visually impaired consumers due to technology related issues involving the use of speech output software will become available following the identification of a local provider, who can assist with scripting and provision of training to two DSB Assistive Technology Consultants to learn this skill.
   - Through the development of a marketing plan, with the assistance of NC DHHS Public Information Office, DSB will increase and improve its marketing to employers.

2. By 2008, the number of visually impaired individuals who will be receiving services from the North Carolina Division of Services for the Blind, Independent Living Program, will increase by eight percent.

Strategies:

- Through the development of an outreach plan, utilizing the assistance of NC DHHS Public Information Office, there will be an increase in awareness of DSB services to potential consumers.
- Development of an outreach plan, implementing the plan, and tracking outcomes will be assigned to a DSB position as a primary responsibility.

3. By 2008, the North Carolina Division of Services for the Blind will increase statewide staff communication, as measured by ninety-five percent of staff indicating "a positive improvement" by survey.

   Strategies:

   - Through the installation of video conferencing equipment in all district offices, with the assistance of the Division of Information Resource Management, DSB will be able to establish communication with staff in all district offices simultaneously.
   - Through the use of video conferencing in all district offices, DSB will be able to conduct statewide staff meetings and trainings on a regular basis.

Division of Social Services

Mission: The Division of Social Services (DSS) is committed to providing family centered services to children and families to achieve well-being through ensuring self-sufficiency, support, safety, and permanency.

Vision: All programs administered by the Division of Social Services will embrace family centered practice principles and provide services that promote security and safety for all.

The Current Environment

With few exceptions, North Carolina's social services system is state supervised and county administered. The federal government authorizes, provides regulations and funding for programs in each state while the State provides funding, policy, technical assistance, and support. Actual delivery of services and benefits to customers is performed by the 100 county departments of social services and non-profits across the state.

While Child Support services are primarily provided by county departments of social services, services in 28 counties are provided by 16 State operated Child Support Offices and in 9 counties, the Child Support Program is administered by another county entity or is privatized. Refugee Services and some family support services are provided by non profits across the state.

The Division of Social Services (DSS) provides program supervision, policy, training, technical assistance, and consultation to the county staff and non profits who work in the following program areas:

- Child Protective Services
- Family Preservation and Support Services
- Foster Care Services
- Adoption Services
- Food Stamps
- Low Income Energy Assistance
- Crisis Intervention
- Refugee Assistance
- Work First
- Child Support Services (organization and additional DSS responsibilities explained above)

Despite almost uninterrupted economic expansion in NC over the past decade, DSS, like other Department of Health and Human Services (NC DHHS) divisions, facilities and schools, is increasingly stressed by a rapid growth in a demand for services that has not been matched by increases in funding or resources.

Since 1990, NC population has grown from 6.6 million to about 8.5 million, an increase of 22%. Over one million of these people are immigrants to the state.[1] This population growth has been fueled by a robust job market, particularly in construction and high tech, as well as by a growing number of seniors who view the state as an attractive retirement locale. These developments have

expanded the tax base and benefited a large majority of North Carolinians, but other dynamics have had negative impacts that trigger social service intervention.

While the traditional industries of textiles, furniture, and tobacco retain importance in the state, these industries have been struggling due to global competition. In the case of tobacco, government regulation, class action lawsuits, and health concerns have brought about large cuts in production and processing capacity. Displaced workers in these industries are generally not trained for the type of work available in the state's growth areas such as biotechnology, pharmaceuticals, computer software and hardware, electronics, tourism, and construction. Even if training were not an issue, jobs may not be geographically accessible to displaced workers who have little or no resources to relocate.

Still other factors have influenced the need for social services in NC. The state has experienced an increase in single parent families, an increase in teens that do not complete high school, and an increase in children who have difficulty speaking English (not just Spanish speakers, but other languages as well). Substance abuse, particularly methamphetamine use and manufacture, remains a concern. Finally, due to its large military population, NC has experienced a large number of deployments and deaths during the gulf war that impact families and the economy in military communities.

Key Operational Issues

Because of the significant operational issues and opportunities that are impacting DSS, strategies have been developed and are being implemented to address them. In the area of child safety, opportunities are available to improve the quality of service at point of delivery.

The Multiple Response System (MRS) is an effort to reform the entire continuum of child welfare in NC, from intake through placement services. MRS was piloted in 10 county departments of social services (Alamance, Bladen, Buncombe, Caldwell, Craven, Franklin, Guilford, Nash, Mecklenburg, and Transylvania) and has been expanded to the other 90 county DSS offices. The reform is based upon the application of family centered principles of partnership through seven strategic components:

1. Collaboration between the work first family assistance and child welfare programs
2. A choice of two approaches to reports of child abuse, neglect, or dependency
3. A redesign of in-home services
4. A strengths-based, structured intake process
5. Coordination between law enforcement agencies and child protective services for the investigative assessment approach
6. Implementation of child and family team meetings during the provision of in-home services
7. Implementation of Shared-Parenting meetings in child placement cases

Through MRS, clients will experience seamless access to services as they are transitioned from one to another by a single caseworker. Providing these services to families will require social workers to work non-traditional schedules, continuously engage community partners, and view family members as equal partners. Some caseworkers have received training related to MRS, but a funding plan for collaborative training of other DSS staff and community partners needs to be developed.

Outdated technology and lack of a statewide case management system and consolidated eligibility system are key operational issues that impact all DSS program areas. For example, MRS cannot succeed unless caseworkers are able to quickly and accurately access comprehensive client information, even when that client has crossed county lines. Food Stamp caseloads are continuing to increase at the local level without accompanying improvements in the technology to assist maximizing efficiency and minimizing errors.

In order to address the issue of outdated or non-existent technology, DSS is one of four NC DHHS divisions providing staff, technical assistance, and oversight for the Department's NC Families Accessing Services through Technology Project.

Families Accessing Services through Technology (NC FAST) is designed to improve the way the NC DHHS and county departments of social services do business. NC FAST introduces new technological tools and business processes that will enable workers to spend less time on administrative tasks and more time assisting families.

NC FAST is implementing a new model for delivering services to families in county departments of social services. The project is committed to releasing tools for workers to use to improve the efficiency and effectiveness of their delivery of benefits and services to families in need in NC. The vision of an improved service delivery method includes the following elements:

- **Efficient, effective assessment** - Automated tools for workers to assess needs and determine eligibility
- **Comprehensive case management** - Tools to help workers track cases, share information, and coordinate services across programs
- **Better outcomes/evaluation information** - Comprehensive data for evaluating outcomes and ensuring accountability across programs

Chronic restrictions in funding also have direct operational impact. For example, many processes could be streamlined by implementing document management and scanning systems, which would have the added benefit of reducing space needed for data storage. Electronic enhancements to the contracts process would also help to reduce costs and increase production speed.

Streamlining policies and process for county social services staff are ways in which DSS makes more efficient use of restricted funding such as in the Food Stamp Program's Simplified Nutrition Assistance Program (SNAP) for older North Carolinians. Other small technology changes also help, such as the use of debit cards in Child Support Enforcement, expansion of web-based services, and electronic court services. Despite these efforts, reduced and restrictive federal and state funding are major concerns across the DSS spectrum. To make up for funding shortfalls, the division hopes to be able to demonstrate the value of flexible federal funding through a IV-E demonstration waiver in foster care. Flexibility in directing funds would be critical to helping DSS target money where and when it is needed in the state rather than be forced into a national model that might not address specific dynamics in NC.

Finally, it is increasingly difficult to fill vacancies in DSS with qualified individuals. Due to the nature of NC's county administered system, experienced staff from counties are ideal choices for many of the Division's vacancies. However, State pay schedules and benefits have not kept pace with many county social service agencies. This results in vacancies remaining open for extended

periods while the jobs are posted often multiple times. This lag time results in increased workloads for those remaining staff who are attempting to continue the work of the Division.

In summary, DSS is aggressively pursuing innovative approaches to case management, performance measurement, and community involvement. While of necessity many of the Division's actions are reactionary, they are increasingly focused on prevention by attempting to influence behavior patterns. Examples are evidence-based program administration where decisions are made on outcome evidence rather than statistical or anecdotal information; and strengths-based structured input where familial strengths are identified and used as building blocks for improvement. Many of these innovative clinical approaches are enhanced – even dependent – upon improved, seamless information access throughout the social services network.

Key Indicators for Success

1. Increase child support collections in order to ensure that children receive the support they are entitled to by the absent parent.
2. Continue to work with local sheriff departments to make off-hour raids in order to locate absent parents who are delinquent in their child support. Past efforts have collected as much as $5 million uncollected child support.
3. Entering into an arrearages collection contract with a private vendor through the attorney general's office.
4. Increase statewide participation in the food stamp program to 75% of potentially eligible individuals by 2008.
5. Identify and share successful food and nutrition outreach initiatives employed in counties or through advocate groups.
6. Identify and implement allowable program policy and/or procedural changes that can positively impact public perception of what is required to apply for and receive food stamps.
7. Analyze quarterly county and statewide measures of participation percentages using census data to determine potential eligibles and food stamp system data for current recipient count.
8. Review denied cases to ensure that denials are accurate and do not discourage potentially eligible individuals and families from participating in the program.
9. Review customer complaints from CARELINE and economic services help desk data to identify potential customer service issues and policy misinterpretations that may affect an applicant's decision to pursue or follow through with a food stamp application.
10. By 2006: Survey data of county LINKS staff and youth will indicate that 65% of youths aging out of foster care have an ongoing support system of at least five (5) caring adults.
11. By 2007: Survey data of LINKS staff and youth will indicate that 80% of youth aging out of foster care will have an ongoing support system of at least five (5) caring adults.
12. By 2008, the number of children who experience a repeat maltreatment due to substance abusing parents will decline by 20%.

13. By 2008, a 90% reduction in the number of methamphetamine-exposed children.

14. By 2008, all 100 counties will have successfully implemented Drug Endangered Children (DEC) teams, while expanding services to address all substance abuse issues with families.

15. By 2008, county departments of social services will have 100% of its staff specifically trained in providing effective services to substance abusing families involved in the child welfare system.

Division of Vocational Rehabilitation

Mission: To promote employment and independence for people with disabilities through customer partnership and community leadership.

Vision: By 2008, North Carolinians with disabilities will live and work in the communities of their choice with economic and other supports available to help them achieve and maintain optimal self-sufficiency and independence.

The Current Environment

As the Division of Vocational Rehabilitation (DVR) strives to assist individuals with disabilities in meeting their vocational and independent living needs, they face many challenges. Among these are the increase in the percentage of the population that is disabled, the changing needs of the job market, increasing clientele with limited English proficiency, and changes in the way citizens expect to access information and support.

To address these challenges, DVR has established six core values that drive all programs and service delivery. These are:

1. Balancing regulatory compliance with valued outcomes as perceived by customers
2. A service mindset as the foundation for success
3. Limiting regulatory burden on direct service staff and external customers
4. Evidence based decision-making
5. A high involvement culture
6. A performance based culture

In addition to these core values, customer and relationship management play an integral part for all programs of the organization. DVR continues to analyze the value being provided by the services being offered through the division. They are also adapting the way they deliver services in order to offer a continuum to accommodate consumers needs. This includes developing more self-service options by using web-based and other technologies to produce:

1. More effective outcomes and therefore more satisfied consumers
2. Lower costs
3. Increased organizational capacity
4. Staff spending a higher % of time using expertise with consumers who need it and can benefit from it most
5. A more integrated approach that incorporates all players in the VR process (employers, vendors, referral sources, other agencies)

By implementing these core values and customer focus, DVR is committed to being performance and strategy driven and having a culture of continuous improvement and change.

Key Operational Issues

To enable DVR to attain its organizational strategy, there are several factors related to operational needs. To begin with, management in the division needs easy access to their data for analysis and decision support which is critical for evidence-based decision making and an outcomes focus.

A second critical operational need is external access to DVR information resources. This is for both external partners and DVR field staff. For the former, DVR needs the ability to make available to external partners some information resources while protecting others. DVR field staff need to access information resources as if they were sitting at a desk in the main office. The field staff needs this level of access even while utilizing computers and networks that are not managed by DVR (such as rehab counselors who are located in schools).

DVR is also very aware of the special needs that persons with disabilities have in utilizing information technology resources. For example, web pages need to work well with screen readers used by those who are visually impaired. Another example is instant messaging, which is an excellent communication tool for people who are deaf or hard of hearing.

Another operational need is in the recruitment and retention of qualified staff. Federal requirements have raised the educational requirements for core staff of DVR, and the need for staff with a second language skill, including sign language, is increasing. State salary classifications and requirements, lack of competitive salaries, and lack of faster processes to change these areas create a difficult workforce issue for the division.

Disability Determination Services
Disability Determination Services, which has reporting ties to DVR, is a leader in the nation in its recent transfer to a paperless environment for processing SSI claims. NC DDS was chosen as a pilot because of its reputation for having effective processes and openness to change. The new system and accompanying reengineered processes have been a big success. Together they have resulted in increased worker efficiency, improved customer service, and access to more meaningful data for management analysis of processes.

In NC, all SSI determinations can be adopted by Medicaid, which in many cases prevents duplicate processing of SSI and Medicaid claims. However, in NC, Medicaid claims can be filed separately or without an SSI claim at all. These Medicaid claims cannot be processed with the new electronic system and associated processes. This creates duplication in systems and processes which reduces efficiency and creates staffing problems.

Key Indicators for Success

Rehabilitation Services Administration Outcomes:

1. Number of individuals who achieve an employment outcome during the current performance period compared to the number of individuals who exit the VR program after achieving an employment outcome during the previous performance period
2. Of all individuals who exit the VR program after receiving services, the percentage who are determined to have achieved an employment outcome
3. Of all the individuals determined to have an employment outcome, the percentage who exit the VR program in competitive, self or Business Enterprise Program employment with earnings equivalent to at least the minimum wage
4. Of all the individuals who exit the VR program in competitive, self or Business Enterprise Program employment with earnings equivalent to at least the minimum wage, the percent who are individuals with significant disabilities

5. The average hourly earnings of all individuals who exit the VR program in competitive, self or Business Enterprise Program employment with earnings equivalent to at least the minimum wage, as a ratio to the State's average hourly earnings for all individuals in the State who are employed
6. Of all individuals who exit the VR program in competitive, self or Business Enterprise Program employment with earnings equivalent to at least the minimum wage, the difference between the percentage who report their own income as the largest source of economic support at the time they exit the VR program and the percentage who report their own income as the largest single source of support at the time they apply for VR services
7. The service rate for all individuals with disabilities from minority backgrounds as a ratio to the service rate for all non-minority individuals with disabilities

State Outcomes:

1. Number of individuals receiving services who reported a high level of satisfaction with VR Program services
2. Retention of Rehabilitation Counselors
3. Recruitment time for deaf and hard of hearing caseload
4. Use and implementation of Evidence Based Decision Making

Independent Living Services:

1. The number of individuals with significant disabilities living more independently after receiving IL Program services as determined by an Independent Skills Assessment administered at the start and completion of each Independent Living Plan (ILP)
2. Number of individuals who report having access to services needed to improve their ability to live more independently
3. The number of individuals prevented from moving to institutions, and who move out of institutions into community-based settings
4. Number of individuals receiving services who reported a high level of satisfaction with IL Program services

Disability Determination Services:

1. Maintain DDS initial claim average processing time within 7 days of the national average
2. Achieve annual decisional/documentation accuracy rate of at least 93% as measured by SSA
3. Maintain performance standards mandated by the exit plan for the Alexander Court case for Medicaid claims (no more than a 70 day average processing time and completion of at least 90% of claims in 70 days)
4. Maintain an annual cost per case that is less than the national average
5. Retention of disability examiners
6. Recruitment of qualified medical staff

Assistive Technology Services:

1. Percentage of customers satisfied with program services
2. Percentage of customers who achieved improved access to and/or acquisition of assistive technology

NC Council on Developmental Disabilities

Mission: To ensure that people with developmental disabilities and their families participate in the design of and have access to culturally competent services and supports, as well as other assistance and opportunities, that promote inclusive communities.

Vision: Building Bridges to Community

The Current Environment

The North Carolina Council on Developmental Disabilities (NCCDD) is a 34 member gubernatorial appointed body and is part of a network of organizations created by Federal Law (PL 106-402), the Developmental Disabilities Assistance and Bill of Rights Act, to promote the best services and supports for persons with developmental disabilities. Essentially, the council is an incubator for innovative approaches to addressing the needs of persons with developmental disabilities in NC.

As a result of a comprehensive Five Year State Plan development process, a number of developments were identified that provide direction for statewide quality assurance/quality improvement activities and priorities in the coming five years. These include public input from the recent listening sessions, the statewide MH/DD/SAS systems transformation, and quality improvement activities funded by the NCCDD under Ecology for Change.

Ecology for Change is a project that epitomizes systems change activities that is consistent with the federal mandate under the DD Act, and is also consistent with the federal and state authorities' desire to increase accountability. The NCCDD initiative Ecology for Change was developed as a way to deliberately build systemic change as an effort to assist with the implementation of NC's System Transformation. Initial efforts emphasized training for local Consumer/Family Advisory Committees, and have currently shifted to focus on "individualizing services and supports" through community, regional and state connections between Council projects, local management entities, providers of DD services, people with DD and their families, and local grassroots organizations. Through Council funding, contractors provide technical assistance, training, and consultation to foster these connections, increase the chances for successful implementation of the system reform and systemic change.

In the 18 listening sessions held across the state to help develop the NCCDD Five Year State Plan the following quality improvement concerns and recommendations emerged as clear priorities:

> (1) More comprehensive data (such as service delivery, waiting list information and performance outcome measures) is needed to effectively plan, evaluate and advocate for services;
> (2) Consumers are seeking more active roles in planning and monitoring services; (3) From a local perspective, consumers perceive fragmentation and lack of coordination between providers, local management entities and other agencies. (4) Consumers are seeking adequate choice in providers and more qualitative information about available providers.
> (5)Consumers are seeking opportunities to develop new leadership; build a stronger

grassroots, self advocacy movement; and increase the base of knowledge about legal & human rights related to responsibilities.

The NC Division of MH/DD/SA Services is the primary agency responsible for administering the services and supports for persons with developmental disabilities. In response to the General Assembly, it has recently initiated statewide system transformation. The plan for the reform articulates a number of ambitious and laudable goals, including approaches to identifying and using existing performance benchmarks and developing common outcome expectations across the professional and consumer community.

The listening sessions also identified as priorities community living, assistive technology, healthcare and justice system issues for people impacted by developmental disabilities in NC. While NC is making progress in creating more opportunities for services in the community, the progress is slow.

NC's over-reliance on "legal services", such as group homes and institutions is out of step with contemporary policy and practice, as supported by the US Supreme Court's Olmstead ruling. The NCCDD seeks, under the Plan, to advocate that the state DD authority initiate long-range planning for census reduction in both the developmental centers and the state's ICF-MR/DD group homes. Such work should be concomitant with renewed efforts to make participant directed supports available statewide. Constituents also voiced concerns with the justice system. If encounters with the justice system occur and developmental disabilities are not appropriately addressed, the result is often unequal treatment. NCCDD's Partners in Justice project has trained people with disabilities, their family members, developmental disabilities professionals, and law enforcement professionals in order to improve awareness and interactions.

Improved access to health care was also identified as a priority. NCCDD has made use of two nationally recognized health resources. The Area Health Education Centers provide training to physicians, dentists, registered nurses, and other health-care professionals. Educational opportunities include those for family practitioners regarding issues related to young adults with developmental disabilities. The Cecil G. Sheps Center for Health Services Research has also played a role in improving health care access related to persons with developmental disabilities by providing practical and comprehensive input into policy development. NCCDD has also released funds in the area of wellness, promoting a pro-active, consumer-centered approach to healthy living.

Additionally, access to evaluation, professional support and education of individuals in the use of their newly acquired assistive technology equipment is unavailable in most parts of the state.

Key Operational Issues

Developmental disabilities funds are obtained by the State from the US Department of Health and Human Services, Administration for Children and Families, Administration on Developmental Disabilities. Funds are made available through PL 106-402, the Developmental Disabilities Assistance and Bill of Rights Act (42 United State Code (USC) 15001 et seq.), as amended. Based on responses to Requests for Applications (RFA) to satisfy goals and objectives in a Five Year State Plan (required by the DD Act), the NCCDD makes sub-grants to public agencies and organizations. These sub-grants are made under the terms of a "Performance Agreement" that incorporates a comprehensive program narrative and budget.

Each year the NCCDD fulfills its responsibilities by distributing nearly $1.4 million in federal funds for projects and activities. These projects and activities vary widely in scope. Grantees may be state or local advocacy organizations, grassroots disability groups, state or local governmental agencies or such diverse community groups as churches, transit systems or local schools. Most of the NCCDD funds are given out competitively through Requests for Applications (RFAs). An RFA contains a concept that the NCCDD would like to see implemented and asks the potential grantee to describe, in an application, how that concept might be implemented. RFAs are published annually in the NCCDD's newsletter, "Bridges to Community." This publication is widely distributed in the state.

The NCCDD also provides a limited amount of funds on a non-competitive basis. Throughout the year, unsolicited ideas for possible NCCDD activities that are consistent with goals and objectives within the Council's State Plan may be received from agencies and organizations. The NCCDD, prior to further action, may approve these conceptual ideas for potential development and implementation. The requirements for development and implementation of these potential grants are the same as the competitive grants.

Key Indicators for Success

1. Employment: Through council projects, people get and keep employment consistent with their interests, abilities and needs.

2. Education: Through council projects, students reach their educational potential and infants and young children reach their developmental potential.

3. Housing: Through council projects, adults choose where and with whom they live.

4. Health: Through council projects, people are healthy and benefit from the full range of needed health services.

5. Child Care: Through council projects, children and families benefit from a range of inclusive, flexible child care options.

6. Recreation: Through council projects, people benefit from inclusive recreational, leisure, and social activities consistent with their interest and abilities.

7. Transportation: Through council projects, people have transportation services for work, school, medical, and personal needs.

8. Quality Assurance: Through council projects, people have the information, skills, opportunities, and supports to live free of abuse, neglect, financial and sexual exploitation, and violations of their human and legal rights, and the inappropriate use of restraints or seclusion. Quality assurance systems contribute to and protect self-determination, independence, productivity, and integration and inclusion on all facets of community life.

9. Community Supports: Through council projects, individuals have access to other services available or offered in a community, including formal and informal community supports that affect their quality of life.

Office of Economic Opportunity

Mission: The mission of the Office of Economic Opportunity (OEO) is to administer grant programs that provide opportunities for low-income individuals and families to become self-sufficient through the provision of financial resources to community action agencies, limited purpose agencies and other community-based organizations for programs that will substantially reduce the number of citizens in our state who are living in poverty.

Vision: By 2008, the OEO will be a leader in providing grant opportunities and technical assistance to local subrecipients resulting in strategies and projects that better address the causes, conditions and problems of poverty in North Carolina.

The Current Environment

As an administrator of three federal grant programs, OEO directs federal money as well as provides training and ensures compliance with spending among the many local community action agencies (CAAs) and other community-based organizations throughout the state. The Community Services Block Grant (CSBG) Program provides a range of services designed to assist low-income people to attain the skills, knowledge, and motivation necessary to achieve self-sufficiency. The Weatherization Assistance Program and Emergency Shelter Grants Program enable CAAs and other community-based organizations to mobilize resources for the poor at the local level.

OEO coordinates its activities with other Department of Health and Human Services (NC DHHS) agencies, particularly NC DHHS Rural Health, since both address unmet needs in both rural and urban underserved areas.

Key Operational Issues

A small number of OEO employees write and administer over 200 contracts with CAAs, shelters and other non-profit organizations. OEO has embraced performance based contracting but at times is frustrated with implementation. Specifically, OEO struggles with a contract timeline that requires performance data to be submitted well in advance of contract expiration dates. In addition, a majority of the recipients, working as non-profits, represent the only vehicle for assistance in the communities where they operate, especially in rural areas. Further complicating performance is the high level of turnover among subrecipients that results in lost expertise and interrupted services.

In order to balance tight funding levels with identified needs, OEO would like to promote program efficiencies by funding fewer subrecipients covering larger service areas. Since OEO is constrained by federal regulations that determine which subrecipients receive funding, the only mechanism to accomplish program efficiencies is through increased accountability, training and education.

Operationally, OEO would benefit by electronic invoicing and online business transactions. Efforts are underway to convert forms and funding requests to accomplish this. Because the

contract process is so time consuming and labor intensive, reform of departmental procedures and further automation would benefit the division.

Key Indicators for Success

Community Service Block Grant Program

1. The number of low-income families achieving economic self sufficiency (income above the federal poverty guidelines)
2. The number of participants obtaining employment (wages above minimum wage and lasting for at least 90 days)
3. The number of participants completing educational/training programs
4. The average increase in annual income per participant family

Weatherization Assistance Program

1. The number of dwelling units weatherized
2. The average energy savings per unit weatherized
3. The average cost per unit weatherized
4. The average reduction in energy usage for the households whose homes were weatherized

Emergency Shelter Grants Program

1. The number of individuals provided emergency shelter during the year
2. The number of emergency shelters provided funding during the year

Office of Education Services

Mission: The mission of the North Carolina Department of the Health and Human Services (NC DHHS), Office of Education Services (OES) is to provide quality, comprehensive, developmental and educational opportunities for eligible students ages birth to 21 and their families so that students can develop the skills necessary to lead productive lives—vocationally, socially and personally—resulting ultimately in the achievement of their highest potential for independent and successful lives.

Vision: The vision of OES is to be a national leader in providing early intervention and education services to children who are deaf and/or blind by ensuring that those children have the educational, communication, and technological tools to reach their highest potential.

The Current Environment

The OES is in a unique position within NC DHHS since they provide education to students in a variety of settings that include birth to three for Early Intervention, birth to five for Governor Morehead Preschool, three to 21 in the Resource Support Program, and five to 21 in the residential schools. At the Schools for the Deaf and Governor Morehead School students have access to the NC Department of Public Instruction Standard Course of Study as well as Life Skills curricula.

The OES performs the functions of an Office within NC DHHS and a central office for a school system. In fact, OES is the central office for the NC DHHS Local Education Agency (LEA) and the OES Director is the Superintendent for the LEA. The NC DHHS Secretary functions as the School Board for the NC DHHS LEA. Therefore, OES makes every effort to keep educational issues at the forefront at NC DHHS and is very proactive about maintaining good communications with other divisions, facilities, and schools. Being proactive in this way helps them to stay in the loop and have the opportunity to provide input to initiatives affecting the beneficiaries of their programs and services.

Like other divisions, facilities and schools of NC DHHS, OES is impacted by growth in the population served. Other factors that directly affect OES are an increase in students with multiple disabilities and mental health diagnoses, the increase in the Spanish speaking population and increases in transportation costs. These factors are requiring OES to evaluate changes to the delivery of their programs and services. To ensure that the students with the greatest needs who require the most restrictive environment are served residentially, OES is considering increasing the length and types of summer programming to ensure that students receive a wide variety of services to meet their many needs. In conjunction with this, they plan to enable more students to remain in their home schools through the use of outreach services and assistive technologies. Such a change would also require OES to increase outreach to public schools and staff. They also plan to ensure that students receive the skills needed to be competitive in technology focused environments.

Already recognized as a national leader for early intervention with deaf and hard of hearing children, OES plans more regional service delivery and employment of highly qualified teachers, providing continuing staff development to ensure that teachers are able effectively to instruct students with multiple disabilities so that outcomes are improved. In addition, OES plans to

partner with NC Department of Public Instruction and other Local Education Agencies (LEAs) to explore options to address the current gap in services for three to five year olds who are deaf and hard of hearing.

Key Operational Issues

One of the greatest operational issues facing OES is creating a highly functional IT environment. OES and the department lack the expertise for creating such plans for a school system. This makes it extremely difficult to be visionaries in a variety of IT planning processes, including how to best utilize accessible technology, assistive and other technology as a teaching tool or how to develop viable vocational options for children. OES does have access to various tools, such as E-rate funding, a possible 90% match program provided by the federal government for IT connectivity in schools which is based on the percentage of students who receive free and reduced lunch rates. While having this funding to support IT initiatives is a tremendous benefit, expertise is needed to guide schools in long-range planning as well as navigating the rapidly changing fields of assistive technology, career options, training availability, web-based instruction for students, and virtual classrooms. Virtual classrooms would enable students to take advantage of the many virtual classes now available as well as enable teachers to attend online workshops.

Also related to IT, OES does not currently have access to NCDPI's newest student information management system, NC Wise. The schedules from NCDPI do not project NC DHHS involvement until 2008, and even then, OES may not be able to access individual school data without special equipment. Another issue in IT is the need for OES to access the LAN on each school campus to access information that is posted locally.

In the area of human resources, OES is facing a challenge meeting federal and state requirements for highly qualified teachers. To address this, OES is collaborating with the licensure department at NC Department of Public Instruction (DPI); working with the teacher training program for visually impaired teachers through North Carolina Central University (NCCU) and for teachers of the hearing impaired at University of North Carolina at Greensboro(UNC-G), Barton College and Lenoir-Rhyne College; recruiting more aggressively outside the state; seeking legislation for higher teacher supplements; providing multiple professional development opportunities for teachers and teacher assistants; and exploring options for developing their own teacher licensure courses within the department. Human resource (HR) needs in the schools also include additional staff with more diverse skills for working with children with multiple disabilities and more staff trained in working with the latest developments in assistive technology.

Related to early intervention, OES wants to equip early intervention teachers with skills in multiple methodologies. OES has specific training and awareness needs related to safety issues for going into the natural environments where services for infants and toddlers are required and considered the optimal learning environment (IDEA, Part C). Continued training in safety, the reporting of abuse, neglect, and exploitation, and interaction with domestic violence situations will help teachers handle situations that may be less than conducive to effective intervention.

A final HR need for OES relates to succession planning. Time and funding are limited, and the staff development programs used by the department do not specifically support good management in an educational or residential school environment. To address this, OES has started a leadership training program to make sure they are cultivating leadership from within. OES also plans to participate in the LeadershipDHHS program as appropriate.

Another operational issue and area for opportunity relates to funding streams. For example, when a child is moved from public schools to one of the OES schools, DPI funding does not follow the child. As a result, the educational expense for these students primarily falls on NC DHHS. Additional funding challenges are experienced when local mental health services are needed on OES campuses by students who are not permanent residents of the catchment area of the Local Management Entity (LME).

Additionally, OES competes with all other NC DHHS divisions, facilities and schools for renovations and repairs to its old, outdated buildings. New technology in construction for school buildings is not always available to OES programs**.**

Key Indicators for Success

1. **All professional early intervention staff will become proficient in one (1) oral and one (1) visual communication method for children who are deaf or hard of hearing.**

   Measure: Currently, about 46% of these teachers are proficient in both one oral and one visual communication method. The goal for the end of 2007 is for 85% to be proficient. The goal for 2008 is 100%.

2. **By their graduation, students in the residential schools for the deaf and blind will be able to use multiple technologies to support their communication needs in a global environment.**

   Measure: By 2008, all seniors access assistive technology to meet 100% of their Individualized Educational Program (IEP) goals.

   Measure: By 2008, all seniors on a diploma pathway will pass the computer skills test (which is a high school exit standard).

   Measure: By 2008, high school students will have at least two vocational training options that are in the Information Technology field.

3. **Children identified with vision or hearing needs will begin receiving early intervention services by the age of six (6) months.**

   Measure: By 2008, 100% of children referred by the age of six (6) months will receive services.

4. **All teachers in kindergarten through grade 12 will attain a level of professional credentials commensurate with or exceeding the highest state and national standards, including dual licensure or National Board Certification as appropriate.**

   Measure: By June 30, 2006, all NC DHHS teachers who need High Objective Uniform State Standard of Evaluation (HOUSSE) credentialing to meet the "No Child Left Behind" criterion of highly qualified will be complete.

   Measure: By 2008, all NC DHHS teachers with career status will have a licensure status of highly qualified.

5. **OES programs will seek to explore and replicate, with needed adjustments, nationally recognized initiatives in communication and life skills areas that will meet the changing needs of hearing and visually impaired children.**

   Measure: Each year, OES will review at least one research-based, nationally recognized program/approach to meet the changing needs of students in communication and in life skills.

Office of Minority Health and Health Disparities

Mission: The mission of the North Carolina Department of Health and Human Services (NC DHHS), Office of Minority Health and Health Disparities (OMHHD) is to promote and advocate for the elimination of health disparities among all racial and ethnic minorities and other underserved populations in North Carolina.

Vision: All North Carolinians will enjoy good health regardless of their race and ethnicity, disability or socioeconomic status.

The Current Environment

The OMHHD focus is to reduce health disparities. OMHHD believes state, local and community approaches to eliminating health disparities should be a unified effort aimed at increasing the capacity of NC DHHS state and local programs and communities to develop effective strategies and collaborative networks between community-based organizations and other local public and private agencies. OMHHD engages faith-based organizations, local non-profits, tribes and other organizations to reduce healthcare access barriers and health disparities in their communities. To equip these organizations, OMHHD provides a range of capacity building services, including training; leadership and skills development; resource development; financial assistance, infrastructure development; consultation and technical assistance. This approach has helped community-based organizations implement sound business practices, ensure fiscal accountability, write successful grants, influence local and state policies and legislation, and mobilize coalitions to address health disparities.

At the state level, OMHHD leads the department in implementing an integrated, comprehensive and coordinated approach to identify and reduce disparities in services, access, and health. The Department's plan, "From Disparity to Parity in Health: Eliminating Health Disparities Call to Action," guides the work of the divisions and offices. Each action plan is tailored to specific services and programs.

In addition to building capacity at the community and state levels, OMHHD has three other essential functions: (1) To conduct research and produce reports that present data about health disparities in terms that a lay person can understand. These reports are used to educate a wide audience on the realities and specifics of health disparities. (2) To provide cultural and interpreter trainings to ensure that culturally appropriate communication, outreach, services and materials are provided to our state's diverse population. (3) To promote legislation and policies to improve access to health services for racial/ethnic minorities.

Looking to the future, OMHHD plans to continue the emphasis at the community and state levels by increasing efforts and resources to support capacity building and infrastructure development. OMHHD will continue to focus on performance and outcome measures for established programs. The Office continues to provide leadership to ensure that issues of health disparities are recognized and integrated throughout NC DHHS programs and services. As with other divisions and offices of NC DHHS, their work will be impacted by two trends in the demographics of NC, an increase in the

Latino and other minority/immigrant populations and an increase in the percentage of people living in poverty.

While organizationally a separate office from the Division of Public Health (DPH), all of OMHHD's human resources, budget, and other administrative support are provided by DPH.

Key Operational Issues

As are other divisions, facilities and schools in NC DHHS, OMHHD is eager for a paperless process for contracts, including tracking and electronic signatures. Currently, much of the process is paper driven requiring excessive manual labor, multiple reviews and delays. This is particularly important to OMHHD because, although the contracts are for small amounts, there is a large volume.

As part of the community capacity building process, OMHHD awards small grants to community agencies via contracts. In some instances, the money can be used to purchase basic Information Technology (IT) equipment needed for operating (e.g., a desktop computer, office software, a printer, etc.). However, since current NC DHHS policy requires that contracts with any IT related expenses receive IT review, even money for a single desktop computer or desktop software package, the contracts experience excessive delays in the approval process. In some instances, these delays have jeopardized the office's ability to award short-term grants. Requirements to utilize the state IT procurement process have also resulted in increased costs and delays. For this reason, OMHHD now has a policy to discourage IT spending in contracts with community agencies.

As with other divisions, facilities and schools in the department, OMHHD recognizes the benefit of and is open to piloting a unified approach to desktop management. Along with other small divisions, facilities and schools within the department, OMHHD has expressed concern that their specific needs would be lost when an enterprise approach to IT solutions is adopted

Key Indicators for Success

Engage state and community-based organizations, faith based organizations, tribes and local health and human service agencies to address the elimination of health disparities.

1. By 2008, increase the overall number of linkages and partnerships by 10% each year.

2. By 2008, increase the number of consultation, technical assistance, and training services by 10%.

3. By 2008, increase the number of organizations that focus on the use of preventive measures to support healthy lifestyles by 10%.

4. By 2008, update the health disparities report card and other resource tools.

Office of Rural Health and Community Care

Mission: The Office of Rural Health and Community Care (ORHCC) assists rural and medically underserved communities and populations to develop innovative strategies for improving health care access, quality, and cost effective delivery.

Vision: The ORHCC will be a national leader in improving the health of North Carolina's rural and underserved people.

The Current Environment

Founded in 1973 as the Office of Rural Health Services, the ORHCC provides technical assistance to rural health centers and small hospitals in rural and medically underserved communities. Since its inception, the office has established 85 community-based rural health centers throughout the state. The office also recruits health care providers to work in rural and medically underserved communities, averaging approximately 130 placements per year, and provides grants for rural and community health centers. These services are accomplished by a staff of 40 program and administrative specialists located in Wake County, and through the issuance and monitoring of over 350 contracts with a total value of $15M.

In its January/February 2006 issue, the *North Carolina Medical Journal* published a collection of articles entitled, "Contemporary Issues in Rural Healthcare." In this issue, ORHCC was prominently named as a pioneer in forging community and state partnerships for healthcare in rural and underserved areas. As such, the office is the lead agency for demonstrations in the delivery and financing of health care for NC DHHS. Presently, ORHCC is spearheading Community Care of North Carolina (CCNC), a national model for Medicaid-managed care. CCNC is a collaborative effort between the state and key Medicaid providers such as physicians, hospitals, health departments, departments of social services, and other community organizations. The objectives are to (1) increase access to care, (2) promote community-based systems of care, (3) achieve enhanced patient care management, and (4) improve quality and cost effectiveness. Currently, over 700,000 Medicaid patients are enrolled in the program. Nineteen staff from the Division of Medical Assistance (DMA) support the continued development and expansion of CCNC, providing Medicaid expertise where needed.

ORHCC has been very successful in helping small Critical Access Hospitals build alliances with larger, regional hospitals. This initiative increases the range of services for smaller hospitals, enhances reimbursement, and often allows them to remain open. Currently, there are 22 Critical Access Hospitals operating in North Carolina.

Through the Medication Assistance Program, the ORHCC provides software and technical assistance to 112 sites throughout North Carolina to assist providers to obtain prescription drugs for their clients. This program utilizes the pharmaceutical manufacturers free prescription drug program for low income, uninsured residents. The annual value of free prescription drugs delivered by the 112 sites is approximately $40 million. The Office is collaborating with the Division of Mental Health/Developmental Disabilities/Substance Abuse Services on an expansion of the system to include mental health patients throughout the state.

The ORHCC is the lead agency for the NC Farmworker Health Program. This program combines federal and state support to provide for outreach, enabling, medical, and dental services for migrant and seasonal farm workers in North Carolina. Currently, the office provides grant funding to 14 health care sites that serve as access points for the state's migrant fee-for-service program.

Key Operational Issues

North Carolina faces an acute shortage of primary care medical providers, especially in its rural areas. This year, it is expected that population growth will exceed the growth in number of physicians. This projection is further compounded by an aging workforce; many physicians who were successfully placed in the 1970s and 1980s are reaching retirement age. The number of medical and dental providers will have to expand to meet the expected shortages. In response, ORHCC has begun a process of expanding recruitment efforts by requesting additional dollars for provider incentives and recruitment staff. Additionally, ORHCC will work with local management entities (LMEs) in support of state mental health reform through recruiting needed psychiatrists and others trained in psychiatric services. Mental health services are critical to the comprehensive care delivered to underserved residents.

Continued federal funding restrictions will increase ORHCC's emphasis on seeking grants to acquire funds from new sources. In addition, documented performance standards for all of its grantees will provide an objective means of distributing available funding.

To respond better to critical health needs in rural and underserved communities, especially the growing number of uninsured residents, ORHCC must maintain active involvement and adjust programs and services to meet changing needs. The biggest obstacle remains lack of funding. Last year, ORHCC funding fell $1.5 million short of requests from rural health centers, which have seen their indigent care load increase dramatically in the past few years, thus necessitating some difficult funding decisions. At a time when successful recruitment is more important than ever, all incentive, funds (used to relocate physicians and help them pay off education loans) were exhausted only five months into SFY 06.

Beyond funding, service delivery will be affected by a variety of demographic trends:

- Immigration, whether legal or through unlawful entry, expands the uninsured population, creates a need for language translation services, and exacerbates the risk for poor health outcomes in minority populations.
- General unemployment and a decrease in industry in rural areas also expand the uninsured population and to some degree cause migration within the state from rural to urban areas.
- An aging population, population growth, growth in the uninsured, decrease in industry in rural areas, unemployment, decrease in primary medical care providers, and the federal budget deficit present a host of significant challenges.

Key Indicators for Success

ITEM	SFY 2005/2006	SFY 2006/2007
To maintain a national ranking of #1 in total placements of health care providers in rural areas[1]	141 total placements	≥ 150 total placements
To maintain a national ranking of #1 in family physician placements in rural areas[1]	40 physicians placed	≥ 40 physicians placed
To maintain a national ranking of #1 in dentist placements in rural areas[1]	38 dentists placed	≥ 38 dentists placed
To maintain or improve a national ranking of #4 in leveraging federal contributions to rural health programs[2]	Total = $2,642,065	Total ≥ $2,642,065
To improve from #2 to #1 a national ranking in the percentage of Rural Disproportionate Share hospitals enrolled in 340B drug pricing[3]	85% enrolled in 340B (24 out of 28 hospitals)	100% enrolled in 340B (28 out of 28 hospitals)
To maintain a national ranking of #1 in the percentage of counties participating in community-based care networks for Medicaid eligibles	92% participation	100% participation

[1]Source: 3R Network Evaluation: Membership Activities Report, January 2005

[2]Source: National Rural Health Association and the National Organization of State Office of Rural Health, FY2003 or FY 2004

[3]Source: Office of Rural Health Policy

Support Offices Profiles

Division of Budget & Analysis

Mission: The Division of Budget and Analysis (B&A) provides leadership and support to NC DHHS and division management through (1) the development, execution and modification of the department's operating budget, (2) the research and analysis of issues that impact the department's budgets, plans and programs, and (3) development of innovative solutions to challenging problems.

Vision: The Division of Budget and Analysis will enhance its capacity to serve as a cohesive group valued for innovative delivery of quality support services to the secretary and the agencies that comprise the department. In achieving this vision B&A will empower employees to continuously improve the quality of services; foster innovative workplace efficiency; promote communication and awareness of the division's role and services department-wide, and forge effective partnerships between the division and its stakeholders.

The Current Environment

B&A plays an important role in two-way communications among the divisions, the NC DHHS secretary, and state level functions such as State Budget, Fiscal Research and the legislature. Working with NC DHHS management, B&A assists in prioritizing assignment of available funds. B&A will also make recommendations to agencies when it determines that common budget sources or program objectives would facilitate program merger or rationalization.

The effect of economic trends that influence the ability of the state to collect tax revenues has a considerable impact upon NC DHHS programs and services. A recessional or static economy reduces the ability of the state to collect additional tax receipts. Inflationary pressure and an expansion in demand for services (often prompted by recession) create demand for additional revenue. The net effect is the need to constrain program growth in some areas and reduce program size and scope in other areas. The budgetary impact of these influences creates a substantial burden on work load and a commensurate change in working relations with divisional budget and program offices.

Key Operational Issues

Good communications, including a common understanding of the information requested and presented, is essential for B&A to accurately collect, analyze, and deliver information. The division relies on formal and informal feedback that will improve communications at both the front end with agencies and at the back end with external stakeholders. Lack of feedback is itself an indicator of poor communication, thus B&A's objective is to break down this kind of communication barrier and actively solicit dialogue.

B&A's role is traditionally reactive in that the division collects data in response to formal requests and legislative mandates. As a result, information often is gathered and disseminated on short deadlines which can have a negative effect on accuracy and quality. Through experience and good business practices, B&A can be proactive by anticipating requests and giving people as much time as possible to respond. From this perspective, B&A supports a broadly owned

information structure both at the state and department level that would facilitate accurate and rapid information access.

Key Indicators for Success

Through informal surveys after major tasks or events, Budget and Analysis will assess performance in the following areas:

1. Effectiveness of communication and technical assistance provided to divisions and offices within the department.

2. Clarity, quality and usefulness of output from divisions and offices.

3. Clarity, quality and usefulness of the output provided by B&A to the secretary that results in the secretary's ability to make informed decisions.

Output and information provided to the secretary will be timely to allow the secretary sufficient time to effectively evaluate the output.

Results of the informal surveys will be utilized to continue to refine efforts to improve delivery of quality support services to the secretary and the agencies that comprise the department.

Division of Human Resources

Mission: The Division of Human Resources aspires to deliver superior human resource services that enhance the ability of NC DHHS offices and divisions meet programmatic and operational challenges.

Vision: In the arena of human services, NC DHHS will be the employer of choice for those who aspire to serve in state government.

Current Environment

HR resource personnel are located within divisions or are shared by divisions and support offices, but formal reporting lines are centralized to individuals within the Division of Human Resources in the Secretary's Office. Department activities are controlled by the State Personnel Act and are overseen by the Office of State Personnel (OSP). NC DHHS HR has autonomy for most day-to-day operations, but at certain times OSP approval is required before hiring, classification, or pay decisions can be approved.

Human Resources exists in a world that constantly shifts emphasis from a centralized control authority to a decentralized business partner to an independent employee advocate. Balancing these roles is challenging but is essential to the success of the organization.

Key Operational Issues

The complexity of laws and regulations governing human resources makes it very difficult to implement creative solutions to the myriad of HR issues. HR operates under a bewildering array of federal and state laws, regulations, and policies that are often contradictory or duplicative. Compliance often results in a high administrative burden and confusion within the workforce. For example, most changes to the State Personnel Act (SPA) have been incremental without consideration of policy conflicts.

Demand and supply of certain occupational groups, such as nursing, and increasing licensing requirements for some professional jobs usually reduces the labor supply, increase wages and make recruitment more difficult. Other economic factors include DOL projections that health care, medical care, allied health and IT are projected to be high growth occupations which has a direct affect on NC DHHS employment. Recruitment of key positions is further affected by the lack of policy and funding for competitive compensation programs.

Even though career banding was suspended in the 2006 Budget Bill, which may be temporary according to OSP, NC DHHS HR is using career banding concepts to evaluate performance management, merit-based employment, delegation of authority, and career development. A change in emphasis in the roles of the classification analysts to compensation/workforce planning and organizational development is planned for the central office.

Human Resources has numerous technology needs that go beyond functionality provided by a robust HRIS, Examples include requirements to track and analyze over 98,000 job applicants per year; increase employee computer access through kiosks and mobile/hand held devices; and implement other technologies that will enable HR to adopt a service / consultative orientation.

HR must participate more fully as a partner in strategic planning with program operations. Improved technology through implementation of a robust Human Resource Information System (HRIS) is a key to helping HR become more consultative and less transactional by redirecting resources to organizational planning and workforce development. Moving to a more consultative HR is enabled by HRIS providing a mechanism for employees to manage HR information. In addition, substantial numbers of NC DHHS employees have internet or intranet access, permitting more educational offerings to be developed as web-based classes.

Key Indicators for Success

1. **Attract and retain high performers**
   - Increase the number of qualified/highly qualified applicants by five percent per year for the next three years
   - Reduce voluntary turnover by three percent over the next three years

2. **Maintain market competitiveness of jobs**
   - NC DHHS pay levels will be at or above the median pay derived from competitive wage surveys

3. **Develop and educate employees, supervisors and managers**
   - Train 100% of newly hired/promoted supervisors and managers in mandated OSP/HHS training within 18 months of appointment

4. **Enhance and maintain effective employee-employer relations and quality of work life**
   - Conduct regular employee opinion surveys and implement formal response mechanisms throughout the Department

5. **Provide for a safe and healthy work environment**
   - Reduce worker's compensation costs, which currently exceed $9M annually, by 10% per year

Division of Information Resource Management

Mission: To provide enterprise Information Technology (IT) leadership to the North Carolina Department of Health and Human Services (NC DHHS) and its partners so that they can leverage technology resulting ultimately in delivery of consistent, cost effective, reliable, accessible and secure services.

Vision: The Division of Information Resource Management will support NC DHHS' commitment to provide nationally recognized quality services to the people of North Carolina through efficient, secure and reliable IT Service Delivery.

The Current Environment

DIRM is facing mandated changes to its organization, processes, and technology plans. Planning and implementing numerous changes concurrently presents a great challenge to all employees in trying to ensure that the outcomes do not conflict or result in degradation of services. Some key examples of these changes are provided below.

- In accordance with legislative mandate, DIRM has been consolidating the IT function throughout NC DHHS. Although the process has been difficult and time consuming, a great deal has been learned about departmental IT operations, and significant improvements are expected in DIRM's planning, service delivery, and execution.

- During the last several years, there has been insufficient funding for employee training in new technologies, which has resulted in a disproportionate and expensive dependence on consultants. DIRM is slated to replace a significant portion of its consultant workforce with state positions during the current and subsequent fiscal years. Technical, supervisory, and developmental training will be critical to successfully negotiating these changes.

- The implementation of state level changes (e.g. IT Consolidation and Senate Bill 991 requirements) requires state agencies to change internal project management and other IT-related processes.

- DIRM has been the first NC DHHS unit to study and implement career banding, a new system of job classification endorsed by the NC Office of State Personnel.

Finally, this NC DHHS five-year business plan will provide much needed information to support the development of a NC DHHS Enterprise Architecture, an initiative that will align IT solutions with the business goals and strategies to provide the most effective delivery of service to the residents of NC.

Key Operational Issues

DIRM has identified a number of risks and opportunities surrounding its business operations. These include:

- **Adequacy of Funding and IT Obsolescence**
  The continuing use of non-recurring funds to address recurring technology needs is a key factor in DIRM's inability to properly address replacement and/or upgrades of hardware and software and creates difficulty in maintaining an underlying infrastructure to meet the needs of all departmental projects and initiatives. DIRM has engaged ITS and will continue to work with them on replacing aging infrastructure systems.

  Among the many responses to these challenges, DIRM exercises careful stewardship of the state's limited resources with the goal of obtaining the most efficient, cost effective IT solutions and approaches for NC DHHS. The division works closely with NC DHHS and the Office of State Budget and Management (OBSM) to develop strategies for identifying adequate funding for DIRM's operations, including funding to support career banding.

- **Workforce Turnover and/or Skill Erosion**
  As with other businesses, DIRM experiences turnover due to workforce aging, lack of opportunities for learning new skills or expanding existing ones, and compensation-/quality of worklife issues. All of these issues have caused DIRM to be overly dependent on a contracted workforce that not only creates a higher current operating cost but also fails to seed the regular workforce with skills and systems knowledge required for long term stability. Inadequate funding and state compensation policies also impact DIRM's ability to retain and reward existing employees, attract qualified candidates for IT positions, and send staff for training to maintain technical certifications.

  To the extent possible, DIRM is aggressively converting its contract workforce to full time state positions with an eye towards key replacements, both in terms of IT skills and business management expertise. As a part of this plan, DIRM will develop a training plan to provide and maintain much needed workforce training certifications. DIRM was also the first NC DHHS unit to implement career banding.

- **Inadequate Business Planning and Communications Prior to Initiating IT Projects and Solutions**
  DIRM's traditional view of customer service has been to focus and respond to individual requests for projects, purchases and overall IT assistance. This fragmented approach was driven by funding silos as much as a desire to respond to a particular customer at a particular time.

  By improving communication between business representatives and DIRM project teams, DIRM will increase the IT employee's knowledge of program business goals and strategies. This, in turn, will allow DIRM to act as more of a business partner to the divisions and make recommendations that more effectively support program objectives while at the same time blending into an overall enterprise architecture for the department. In addition, work is underway to establish a business led IT governance

board for the department.

Key Indicators for Success

1. **DIRM will improve customer satisfaction**

   A. Increase responsiveness to customer needs

   B. Increase NC DHHS help desk call resolution capabilities

   C. Develop and maintain a catalog of services

   D. Develop and provide customer awareness training and effective communication of DIRM's programs and services.

How do we measure?

- Measure and trend customer requests for assistance, consulting, enhancements, training or any other customer needs using documentation or tracking mechanisms currently available. Develop new tracking mechanisms if needed.
- Measure and trend initial contact resolution rates for all NC DHHS customer support staff using existing documentation or tracking mechanisms to gather this data.
- Establish that all technical support requests department-wide follow common standards that can be measured, tracked and trended regardless of documentation or tracking mechanisms being used to gather the data.
- Establish customer feedback and follow-up for customer requests for assistance, consulting, enhancements, training or any other customer need.
- All information technology (IT) staff department-wide will have customer satisfaction components incorporated into their work planning and performance review processes.
- Improve the DIRM website to provide customers more information about DIRM's services and programs.

2. **DIRM, in partnership with NC DHHS business units, will insure that the department's business needs are driving all technology decisions.**

How do we measure?

- Create a departmental information technology (IT) governance board
- Evaluate all IT projects to determine whether an appropriate business need is being accomplished by the proposed work.
- Staff a business liaison position in DIRM and evaluate its effectiveness with the business units through customer feedback and surveys.

3. **DIRM will maximize cost avoidance through automation efforts and efficient use of staffing. DIRM will provide cost effective technical solutions by eliminating redundancy and taking advantage of enterprise solutions.**

How do we measure?

- Identifying redundant technology requests and installations from multiple divisions. Consolidating technology where and when it is appropriate for the department.
- Use state enterprise services as appropriate instead of developing parallel technical or support infrastructures where appropriate.
- Continue to analyze and convert the use of contractor staff to state staff. Use contractors in limited scope circumstances or when deliverables can be clearly identified and defined.

4. **DIRM will increase the training and certification level of its staff to take advantage of current knowledge and trends in information technology and the management of technology.**

How do we measure?

- Appoint a training coordinator who will plan and coordinate technical training as it relates to information technology.
- Establish a department-wide information technology training plan. Track progress as the plan is implemented.
- Increase the number of project managers that have Project Management Professional (PMP) certification from the Project Management Institute or equivalent organizations.
- Increase the number of technical certifications.

Office of Citizen Services

Mission: The purpose of the Office of Citizen Services is to guide citizens through the human resource delivery system by providing accurate and speedy information and referral for services to the proper department or agency and resolving customer complaints.

Vision: The North Carolina Department of Health and Human Services' Office of Citizen Services has created a system that significantly enhances collaborative efforts with human service agencies in government and non-profits as well as with information and referral stakeholders across the state by ensuring that we are providing the most comprehensive state of the art service through the CARE-LINE, NC DHHS Ombudsman Program, NC DHHS Disaster Coordination Services and the Secretary's Customer Service Initiative.

Current Environment

A critical factor in the Office of Citizen Services to achieve its vision is collaboration and cooperation both within and outside of the department. There are three primary areas of collaboration that are important. First, as the "front door" to the department for citizens with questions or issues, OCS needs to be knowledgeable of the implications of changes to programs and services that citizens may be calling about. When OCS is in the loop when such changes are being planned, the office can be better equipped to provide support to citizens who call with questions, including providing automated menu driven answers to anticipated questions.

Secondly, the more knowledgeable OCS staff are about the programs and services offered throughout the department, the better able they are to respond to questions without having to refer calls. To acquire and maintain the knowledge to provide such support, OCS staff must continually be trained about NC DHHS programs and services, collaborating with divisions.

Thirdly, OCS plays a critical role during state emergencies, such as hurricanes. They bring much needed human services needs awareness to crises response teams, such as the reality of medication needs for displaced victims. As a call center that is viewed as a leader in the state, OCS also plays a central role in fielding calls related to a disaster or emergency. For these reasons, it is very important that the office stays in the loop with any disaster coordination efforts happening in the department.

Key Operational Issues

OCS has come a long way since the days of Rolodex, hand written notes and paper manuals. The office is at the leading edge in utilizing technology to serve citizens. The office recently implemented a new call center system and is in the process of implementing, along with stakeholders across the state, a sophisticated, statewide centralized web-based information and referral data repository called NC Care Link.

While the office does have good tools to serve citizens, they have two key operational needs. First is access to important departmental data that will allow them to better serve callers. For example, OCS is working to become HIPAA compliant so that access to Medicaid data will

enable them to handle more first level responses when questions are received. The second important operational need is more call center staff and space to house them. Currently, 20%–30% of callers receive a busy signal because of the limited staff size.

Key Indicators for Success

1. **Implement a statewide centralized web-based repository called NC Care Link through collaboration with statewide government and non-profit agencies**

By 2007, all four NC Care Link pilot projects will be fully operational by contributing 100% of program information and resources to the web-based centralized data repository, NC Care Link and handling all inquiries using the NC Care Link repository. In addition, 17 additional stakeholders will begin implementing the system, ensuring that the repository contains program services from all 100 North Carolina counties.

2. **Enhance collaboration with NC DHHS Divisions in our role as the NC DHHS portal of entry, striving to handle more inquiries without sending to divisions/offices within NC DHHS thus decreasing divisions/offices workloads - One Stop Shopping for NC DHHS customers.**

By 2008, OCS will become a HIPAA business associate of all NC DHHS divisions/offices by providing functions that are more cost effective and customer driven, serving as more of a one stop shop for NC DHHS customers. By becoming a business associate, OCS will have access to more customer information and be able to handle more calls directly on the CARE-LINE. 70 percent of NC DHHS calls will be handled directly by OCS staff, an increase of eight percent by the end of 2008.

3. **Build on already established relationships with elected officials in assisting their constituents.**

By the end of the 2006 legislative session, outreach that focuses on all services offered by OCS will be conducted with members of the General Assembly, focusing on the benefits of OCS services to legislators and their constituents. In addition, monthly e-mails will go out to established contacts for all NC elected officials regarding OCS services with an emphasis on relationship building with constituents. In addition, statistical reports that outline specific constituent concerns will be provided to legislators that have referred their constituents to OCS for human service assistance.

4. **Foster a cohesive unique relationship with NC Emergency Management (EM), bringing human services to the forefront in the EM organization thus serving as more of an integral part of EM.**

By the end of 2006, NC DHHS will play a more active role in the human service component of NC Emergency Management, influencing how services are carried out before, during and after a disaster/emergency situation. Specifically, OCS will play a key role in restructuring the statewide sheltering/mass care plan, and OCS will actively serve on EM committees that affect the delivery of human services.

5. **Enhance both computer and telephone technology for OCS' CARE-LINE and Ombudsman services that will increase staff productivity and allow for better customer service.**

By the end of 2007, statistical data from computer and telephone technology will be used to demonstrate gaps, trends and areas that staffs' knowledge and skills need to be improved to allow for more productivity. A more streamlined tracking system will be implemented that demonstrates information given vs. referrals, time on calls, hot topics, areas of need, and information box utilization. By the end of 2008, a customer service telephone survey system will be implemented.

6. **Educate and encourage NC DHHS Executive Management, Division Directors and staff within NC DHHS divisions/offices to use OCS database and phone system statistics to improve NC DHHS services overall and assist in making program and policy changes based on the data and identifying gaps in services.**

By 2007, OCS management will meet one on one with NC DHHS leadership and every NC DHHS division director and implement a process for collecting and compiling data in a format that serves as a tool for all division directors.

7. **Increase outreach efforts regarding services that are offered through OCS and educate NC DHHS employees about OCS services.**

By 2008, a five (5) year outreach plan will be established. An overview of OCS services will be incorporated in all employees' orientation as well as the CSTF effort and policies relevant to customer service. NC DHHS HR offices will submit quarterly reports, indicating numbers of employees receiving orientation regarding OCS services and CSTF work.

8. **Provide sufficient training to OCS staff to increase knowledge of human services and sharpen skills.**

By 2008, an OCS training plan will be created that allows for set in-service trainings on NC DHHS programs and services and a monthly e-mail reminder will be sent to all divisions/offices, soliciting information changes and additions to program services.

9. **Encourage NC DHHS divisions/offices to collaborate with OCS and use OCS as a resource to decrease duplication across NC DHHS by streamlining communication and incorporating OCS in more task force/committee work within the divisions to receive more of an internal and external customer perspective.**

By mid 2007, OCS management will meet with NC DHHS executive leadership and NC DHHS division/office directors, provide an overview of OCS services, solicit partnerships and serve on at least one work group or task force or committee with every division. In addition, OCS will create a NC DHHS Programs and Services Committee. The purpose of the committee will be to meet every month to discuss program/service changes and additions to ensure OCS staff are handling all inquiries correctly and to ensure any needed collaboration across the department is being achieved.

Office of Internal Auditor

Mission: To provide the management of the North Carolina Department of Health and Human Services (NC DHHS) with ***independent*** audits and analysis of various functions and programs within the department. This includes operational audits, performance audits, compliance audits, financial audits and special investigations. The office's over-all objective is to provide management with ***objective*** information, analysis, appraisals, recommendations and pertinent comments which facilitate management to properly discharge its responsibilities.

Vision: NC DHHS will have minimal exposure to audit risk as a result of effective and efficient control systems that are audited/reviewed on a regular schedule.

The Current Environment

The NC DHHS Office of Internal Auditor (OIA) reports directly to the NC DHHS Assistant Secretary for Policy, Planning and Compliance. The audit and technical assistance services they provide are normally at the state level; however, OIA has also performed audits and investigations at the county/subrecipient level when requested. The office is comprised of nine staff: a director, a manager, six auditors and one administrative assistant. Of the six auditors, three are permanently dedicated to work with specific programs: two to the Medicaid program and one to the Women, Infant, and Children (WIC) program. This leaves only three auditors to cover all the remaining agencies of NC DHHS.

In an ideal world, the office would perform routine audits/reviews of control systems throughout the department to ensure that the department's exposure to risk is minimized. However, the office lacks the personnel resources to operate in this way and, consequently, primarily operates in a reactive mode. Most of the staff's time over the past four or five years has been spent reacting to federal and state audits. When there is a finding, OIA assists the divisions, facilities and schools in responding, often resulting in reductions of paybacks. Reductions that result from OIA assistance are significant—a recent finding in IVE was reduced $60 million. OIA will also conduct a subsequent review to ensure that corrective actions have been implemented.

OIA occasionally relies on assistance from agencies outside of NC DHHS, most notably the NC Office of the State Auditor (OSA) and the State Bureau of Investigation (SBI). When the scope of an audit exceeds the OIA's resource capacity or when subpoena authority is needed, assistance is requested from OSA. When fraud or embezzlement is uncovered by OIA, OIA will turn findings over to the SBI for further investigation and prosecution.

When requested, OIA also provides assistance to the divisions' subrecipient monitoring sections. This is primarily in the form of training divisional staff on monitoring financial controls and assisting the divisional staff in developing financial monitoring guidelines and/or forms. When requested, OIA also reviews proposed program audits/edits for any new Information Technology (IT) systems that have financial or accounting functions.

Key Operational Issues

The primary operational issue facing OIA is the need for more staff. Since three (3) of the six (6) auditors are permanently dedicated to specific programs, only three (3) auditors are available to respond to requests from the rest of the department. Given this staffing challenge, it is next to impossible for OIA to achieve their vision of proactively monitoring controls and making process recommendations that reduce the department's risk of audit findings.

Key Indicators for Success

OBJECTIVE
Provide NC DHHS management with objective information, analysis, appraisals, and recommendations in order to discharge properly management's responsibilities.

Performance Indicator
OIA will assist NC DHHS divisions, facilities, and schools in developing the audit response to outside (federal/state) audit report findings. OIA will also ensure that corrective actions have been taken to prevent the reoccurrence of the audit finding in subsequent audits.

OBJECTIVE
Encourage NC DHHS divisions, facilities, and schools offices to collaborate with OIA and use OIA as an objective resource when the need and/or situation arise.

Performance Indicator
OIA will conduct a survey of all divisions, facilities, and schools requesting information about how OIA can better assist them.

OBJECTIVE
Recommend policy changes to enhance compliance and accountability.

Performance Indicator
OIA will provide input to strengthen policies, enhance internal controls, and improve compliance.

Office of Policy and Planning

Mission: The Office of Policy and Planning (OPP) will work with divisions and offices to develop effective policies, plans and procedures; analyze work processes and recommend improvements; and facilitate performance reviews of programs and services so that the NC Department of Health and Human Services can achieve continuous improvement.

Vision: A results oriented culture will thrive throughout NC DHHS and the OPP will be viewed as a leading factor in performance management and continuous improvement initiatives.

The Current Environment

The OPP has received positive recognition for its efforts to improve performance within NC DHHS. Although OPP is not chartered with implementing authority, numerous projects have been undertaken throughout the department that were originated or supported by OPP initiatives. These include the Performance Management Database (PMD) and associated program reviews; other initiatives such as performance based contracting and related information systems enhancements; the current effort to merge the contracts database and the subrecipient monitoring database into the PMD; LeadershipDHHS for identifying and developing high potential employees; and numerous process improvement efforts that have had direct impacts to cost reduction, efficiency gains, and improved service delivery.

OPP also takes on numerous studies and other projects whether initiated through the Secretary's Office or specific request from other NC DHHS agencies, including policy coordination of issues with a multi-divisional focus, the facilitation of multi-divisional work groups on a variety of subjects and development of this business plan.

Key Operational Issues

In general, there is a very positive trend within NC DHHS toward performance based management and the importance of measuring outcomes. There is also a growing awareness of the criticality of data sharing so that better, department-wide decisions are made. However, these positives are frequently accompanied by a fear of change, a possessive attitude toward information, and a tendency to resist true process improvement in favor of layering more monitoring, review and compliance mandates onto existing processes.

The greatest risk to OPP's ability to fulfill its mission is the cultural reluctance to change. In NC DHHS, all too often recommendations for change are viewed as a negative statement about performance rather than as an opportunity for improvement. There is also a department wide focus on program advocacy and delivery of services to specific audiences to the detriment of focusing on how improvements to internal operations can improve ultimate service delivery. Program service delivery is directly impaired by a lack of proper focus on operational improvements. This is especially true where funding and resource levels are not sufficient to meet the demand for services. Doing more with less—and perhaps doing *less* with less—will allow the department to stretch available dollars and improve employee productivity.

Continued success within OPP depends on staff with wide experience, education, and knowledge of best practices in the public as well as private sector that remain inquisitive about why things are done the way they are and committed to continuous improvement. To the extent that it can deliver a value added product that customers see as effective, OPP can aid in building a results oriented culture throughout the department.

Key Indicators for Success

Number of Divisions Requesting OPP Assistance

Measure: Total number of divisions/offices requesting assistance with internal operations and other challenges. Requests for assistance indicate a recognition that OPP does quality management studies and analyses and makes sound recommendations for change and improvements.

Recommendations Implemented

Measure: Percent of recommendations which actually lead to change (both from assignments and requests for services).

OPP Client Surveys

Measure: Informal verbal and written feedback to OPP staff and leadership as well as comments to the Deputy Secretary, Secretary, Division Directors and others which are shared with OPP.

Office of Procurement and Contracting Services

Mission: To provide training, guidance, and operational assistance to all of the North Carolina Department of Health and Human Services (NC DHHS) agencies so that they maximize financial and program capacities through effective procurement and contract practices while maintaining compliance with applicable regulations. This effort will result ultimately in improvements to the individual health, safety, well being, and independence of NC citizens.

Vision: As a recognized national leader, the Office of Procurement and Contracting Services (OPCS) will operate in a high performance culture where procurement and contracting make direct and significant contributions to financial stability and improved service delivery to the people of NC.

The Current Environment

In 2003, NC DHHS began a major effort to implement performance based contracting (PBC) throughout the department. By turning the focus to results, not activities to be performed, PBC defines performance expectations and measures, due dates and milestones, with payments based on outcomes achieved. In support and recognition of this initiative, OPCS was established as a separate unit within the NC DHHS Secretary's Office where it continues to drive PBC in all of the various divisions and offices throughout NC DHHS.

In its leading role, OPCS has three main functions: Compliance; Operational Support; and Training/Research (including studies of automation and electronic data transfer). Along with reorganization of large division contract offices, OPCS will evolve its own structure to meet the needs of the department. This includes structural changes to align resources as well as process and policy changes with a focus on simplifying and streamlining work processes.

In addition to work process and organizational change, automation is a key element of this reform. OPCS is a proponent of automated work processes and tools that would not only track contracts through the approval cycle but would also provide electronic document management for all NC DHHS contracts. Process automation will enable the department to better monitor results of the performance based initiative and use data to help drive continuous improvement.

Key Operational Issues

Performance based contracting is a major component of the NC DHHS performance management initiative. Virtually all NC DHHS contracts now have at least some performance based components that contribute to better financial management and service delivery. OPCS has assumed the lead role in driving the establishment of divisional centers of excellence, working to strengthen the skills and confidence of divisional staff to manage programs and contracts for results, finding and sharing best practice models, assessing training needs, and providing technical assistance.

It is imperative that the skill levels of department contract professionals be upgraded to meet the demands of this new contracts environment. The OPCS training plan will address two aspects of this need: (1) Workshops in contract administration, technology applications, and process efficiency to replace or upgrade current skill sets, and (2) replacing many employees throughout the department who are at or near retirement age and who are involved with contracting in some capacity.

Because of the increased demand for services to be outsourced, agencies lack the personnel resources and expertise to provide services directly. This drives the increase in contracts that are put out to bid by the general public (Request for Proposals, or RFPs). Over the past few years, RFPs have increased by over 100%, and OPCS estimates that this will continue to increase in the foreseeable future.

Key Indicators for Success

1. OPCS will drive expanded use of competitive processes to procure goods and services such as RFAs, RFQs, and RFPs.

2. Contracts compliance rate of at least 90% with the department's general contracting policies while providing quality services to the public.

3. Customer service quality assessed through customized surveys and direct feedback from division offices.

4. Implementation of an automated contracts tracking system that will improve productivity and provide information about the impact of performance based contracting.

Office of Property and Construction

Mission: To provide efficient facility services for all areas of responsibility, with special emphasis on those services that enhance the quality of care for clients of the North Carolina Department of Health and Human Services (NC DHHS) divisions/facilities/schools and ensure work space conducive to the success of its employees in providing client services.

Vision: All NC DHHS employees, clients and visitors will work or reside in facilities that meet or exceed environmental and aesthetic standards that contribute to quality outcomes for all.

The Current Environment

The NC DHHS Office of Property and Construction (OPC) is responsible for budgeting, planning, designing and construction of capital projects (currently authorized projects are in excess of $600 million) for NC DHHS facilities. In addition, OPC manages centralized facility maintenance, repair, and renovation; approves and manages leases for facilities where employees and/or equipment are housed; and, through delegation from the NC DHHS Secretary, is the designated operating authority for the Town of Butner.

OPC is managing four of the largest ever NC DHHS capital projects—the new psychiatric hospital being constructed in Butner, the planning, design and construction of new Eastern Region and Western Region Psychiatric Hospitals, and a new State Laboratory of Public Health/Office of Chief Medical Examiner.

Capital projects for NC DHHS divisions/facilities/schools are significantly impacted by economic trends, particularly inflation in labor and material costs. Even slight changes in the economics of the construction market can create significant capital dollar impacts when the funding available is fixed, which is typical for most state capital construction projects. Re-bidding, redesigning, or requesting funds transfers in an attempt to award construction contracts in a volatile market can create significant delays in projects resulting in the potential for projects to be compromised or canceled.

NC DHHS currently occupies over 900 buildings throughout the state, most of which were constructed in the late 1800s through mid 1950s. Because current funding makes it impossible to keep pace with the maintenance of deteriorating infrastructure, OPC frequently finds itself relying on "critical needs" requests to pay for materials, fuel, labor, utility and vehicular costs that are not accounted for in approved budgets.

Key Operational Issues

NC DHHS needs more flexibility in decisions about the use of capital funding. Money, time, and resources could be saved if, instead of having funding dictated down to the project level, OPC had the ability to manage capital budgets in response to changing conditions. The office has been successful in lobbying for revisions to administrative rules that have improved its ability to get construction projects completed in a timely and efficient manner; however, these efforts have been time consuming and have resulted in small changes at best.

A major risk to the department is the continuing lack of adequate personnel resources and capital and operating funding needed to accomplish optimal results. NC DHHS cannot match competitive wages and benefits for the skilled work force needed to maintain upgraded building systems, particularly in the maintenance sector where technological changes have had a large impact.

OPC is meeting some of these challenges by modernizing maintenance functions, with the intent of having computerized maintenance management systems at NC DHHS divisions/facilities/schools statewide. This will allow the department to track on a comparative basis the efficiency of the various maintenance groups, including use of labor and materials. OPC is also increasing the installation of building monitoring systems to free manpower for other tasks.

Although OPC does not have implementing authority, OPC is a proponent of cost savings initiatives such as "just in time" inventory systems to free space and money currently occupied throughout the department. OPC also recognizes the utility of and is pursuing the use of geographical information systems to monitor and adjust layouts of buildings and work schedules/locations and to assist in life safety issues.

Key Indicators for Success

Employees:

1. Employees have good morale and are actively pursuing assignments.
2. Employees have the tools they need to complete their responsibilities effectively and efficiently.

Capital Budgeting:

1. Project cost centers are established within a reasonable period after receipt of funding from the repair and renovation reserve—goal is 30 days.
2. Funds are allotted and available within the project code so that all contractors can be paid within 30 days of receipt of pay applications.
3. Capital funding requests are prepared and delivered, along with all required documentation within time frames established by the NC State Budget Office.

Design and Construction:

1. Design contracts are negotiated and executed in a timely manner after approval of selection by NC State Building Commission – goal is 30 days.
2. Repair and renovation reserve projects are designed within the funding available from the reserve, pending a warranted change in scope.
3. Projects are constructed within the project budget established by the construction contract award letter.
4. Projects are constructed within the schedule established by contract documents.
5. A minimum of 10% of construction project costs are awarded to HUB contractors.

Maintenance Operations:

1. Facilities are maintained so that CMS, JCAHO, etc. requirements for certification are met.
2. Preventative maintenance programs are in place and executed. A minimum of 90 percent of work orders are completed each fiscal year.

3. Customers are satisfied with the service they receive.
4. Wrench time is at the 70 percent level as a minimum.

Town of Butner Operations:

1. Reasonable citizen complaints about town operations are resolved in a timely and satisfactory manner. Preliminary response is within 24 hours.

Property Office:

1. Lease extensions are negotiated prior to expiration of current leases.
2. New leases are established within the time frame required by internal customers.
3. Leases are consolidated where feasible and economically reasonable.

Office of Public Affairs

Mission: To provide the North Carolina Department of Health and Human Services (NC DHHS) with the tools for communicating its vision.

Vision: The NC DHHS Office of Public Affairs (OPA) will provide the communications know-how to help all NC DHHS divisions, facilities, schools, and programs communicate effectively.

The Current Environment

The OPA provides the department various services related to communications to the public. These include being a centralized point of contact for media, distributing communications through various media outlets, supporting divisions in the development of public relations materials, and providing a professional graphics shop.

In addition to these support activities, the office is leading a significant effort to overhaul the department's website. The new website will be organized around subjects instead of the department's organizational structure, making it easier for visitors to find the information they are seeking.

Another major initiative at OPA is getting prepared for responding to public health events. After taking FEMA classes for Emergency Operations, the office is now certified to lead a Joint Information Center (JIC).

Key Operational Issues

The societal trend towards more reliance on the internet and email for information delivery has the most impact on OPA operations. This trend has created a demand for more staff resources that can work with the web. While this trend offers increased efficiency in information delivery, it presents additional risks. Should a hacker ever succeed in altering information on the NC DHHS website, there could be serious consequences since much of this information is health related. For this reason, OPA works closely with the Division of Information Resource Management (DIRM) to ensure the security of web content.

Key Indicators for Success

OBJECTIVE
Implement a fully integrated, searchable NC DHHS web site that is based on subject areas, not divisions, allowing customers to more readily find information they need without having to be familiar with NC DHHS programs.

Performance Indicator
By 2008, the web site will be operative so that citizens can use it to find out information by subject area rather than by division.

OBJECTIVE
NC DHHS Public Affairs to be lead agency in a JIC that arises as a result of a public health event like pandemic flu.

Performance Indicator
NC DHHS OPA staff will have taken the FEMA class work required for emergency operations by the end of 2006.

OBJECTIVE
NC DHHS OPA will conduct a JIC drill in 2007.

Performance Indicator
By 2008, NC DHHS OPA will be able to run the JIC in an event of pandemic flu or other notable public health event.

OBJECTIVE
Ensure that the public is informed on key public health issues, so they can respond proactively, rather than reactively. Efforts in this area will focus on pandemic flu.

Performance Indicator
By spring of 2006, NC media will have received special outreach/education on pandemic flu via web cast and teleconference.

OBJECTIVE
In early fall 2006, NC medial will receive special outreach/education via a web cast and teleconference on the seasonal flu and present pandemic threat level.

Performance Indicator
By 2007, tool kits will have been developed to help small businesses, churches, schools and the general public prepare for a pandemic.

OBJECTIVE
Create a team of program communicators who can help external and internal audiences better understand divisions' key objectives. Division directors will be asked to identify spokespeople for division visions. Training for these spokespeople will commence in Summer 2006 and conclude by the end of 2006.

Performance Indicator
Training for new staffers will be held quarterly.

OBJECTIVE
Communicate key objectives and their outcomes to internal and external audiences.

Performance Indicator
By fall 2006, public information officers working with division leadership, will develop comprehensive communication plans that focus on divisions' key objectives and use division spokespeople as key communicators.

Office of the Controller

Mission: The mission of the Office of the Controller is to support the North Carolina Department of Health and Human Services (NC DHHS), and all its divisions, facilities and schools in all fiscal operations so that they are accomplished according to state and federal requirements to the benefit of citizens, clients, and employees.

Vision: The vision is to perform all accounting and financial functions for the department and provide accountability for the resources appropriated to the department.

The Current Environment

The NC DHHS OOC sets and interprets all accounting and financial reporting policies and procedures for the department as authorized by the rules and regulations of the NC Office of the State Controller and state statute and federal guidelines and executes all accounting transactions for the NC DHHS. As a centralized service, OOC is charged with establishing common policies and procedures that will yield consistent results for all divisions, facilities and schools.

Although there is a centralized reporting structure, the OOC is physically located at three large sites in Raleigh (Oberlin Road, Albemarle Building and Dix Campus) and six other regional offices around the state. The challenge of operating in numerous locations is compounded by an inability to recruit the human resource expertise needed to support their fiscal responsibilities, and by reliance on old information technology that requires hand processing and paper files.

Key Operational Issues

OOC's biggest challenge is staffing. If the OOC is to meet its mission of ensuring accurate adherence to state and federal policies and fiscal regulations, they must maintain a staff that possesses extensive financial expertise. The inability to pay competitive market rates is a main factor in both the high attrition rate and the difficulty in recruitment of qualified personnel.

The second significant challenge is that OOC conducts business through a patchwork of legacy systems where data are not integrated, systems are hard to maintain and enhance, and where many manual processes are required to pull data and reconcile systems. Current staff knowledgeable about these systems is becoming retirement eligible, creating an urgency to establish succession plans and provide for technology transfer to newer, updated systems when funding becomes available.

In addition, there is extensive manual processing of paperwork, resulting in a vast quantity of hard copy data requiring valuable storage space. These manual processes require numerous handoffs from one person to another, sometimes through the mail service or local couriers, and they are unnecessarily burdensome and time consuming.

OOC would benefit tremendously from upgrades to its legacy systems and implementation of document management technology. Unfortunately, OOC has not received funding priority even though efficiencies could be gained that would impact virtually all NC DHHS operations.

Key Indicators for Success

1. Maintaining a staff that possesses extensive financial expertise in order to interpret and account for state and federal policies and regulations will enable the department to strengthen and maximize financial impact of programs to the citizens of the state.

   Indicator: Minimal to no financial audit findings identified by the Office of the State Auditor annually. Positive performance appraisals and accurate NCAS reports are achieved.

2. Providing clear, strong leadership in the role of promoting an atmosphere of enhanced fiscal accountability and stewardship of the state's/department's assets.

   Indicator: Same as number 1.

3. Modifying and enhancing systems as needed to support the needs and requirements of service divisions and other stakeholders.

   Indicator: Feedback provided from an annual survey to service divisions and other stakeholders on how well their system needs are being met.

4. Striving to provide better support services and communication to service divisions and other stakeholders.

   Indicator: Feedback provided from an annual survey to service divisions and other stakeholders on how well communications and support services are being provided by the Controller's Office.

5. Building an organization that attracts and retains talent.

   Indicator: Low turnover and high performance. However, if items 1-4 are met, the results here would be an automatically achieved.

6. Utilizing all available resources to maximize benefits to populations being supported through initiatives of health and human services programs and facilities administered within North Carolina.

   Indicator: Same as item 5.

7. Maintaining integrity, service orientation, professionalism, responsibility, and respect in the functions of our roles.

   Indicators: Positive feedback from service divisions and public being served as a result of quality work being performed. If all the above indicators were met, this would be achieved.

Part IV:

Appendices

Appendix 1

S.B. 622-10.1(a)

INFORMATION TECHNOLOGY

SECTION 10.1.(a) To support its information technology initiatives, the Department of Health and Human Services shall develop the following:

(1) A detailed business plan.

(2) An information technology plan directly tied to business requirements.

(3) An IT architecture.

The Department of Health and Human Services shall ensure that the planning documents extend three to five years and include detailed shortfall analyses and associated cost assessments. The Department of Health and Human Services shall forward the documents to the Office of Information Technology Services, the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division by December 1, 2005. The Office of Information Technology Services shall review the documents and report its findings and recommendations to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division by January 31, 2006.

Appendix 2

Business Plan Questionnaire

1. Do you have a vision statement? When was it last revised?

2. What is your mission statement? When was it last revised?

3. What demographic trends, economic trends, environmental trends, or other factors will affect your programs and services?

4. How will your programs and service delivery change over the next five years?

5. What are the risks to your service delivery and how are you addressing them?

6. How would you operate differently in an ideal world?

7. Have you experienced obstacles that have prevented your division from delivering a service as desired? If so, please share these examples.

8. What are you doing now to overcome these obstacles?

9. What are the operational and public benefits to making these changes?

10. Please add any other comments that will add to an understanding of your current operations, your plans for the future, and the challenges that you face.

Appendix 3

Summary of Operational Issues

Summary of Operational Issues by Number of Responses

Business Functional Area	Issue Title	Issue Description	Responses
Workforce	Inability to Attract & Retain Qualified Workforce	NC DHHS unable to attract and retain qualified workforce due to noncompetitive salaries and lack of training opportunity to learn new skills.	12
Information Technology	Insufficient Automation of Manual Processes	Lack of automation around very manual processes, including electronic documents, electronic signatures, electronic invoicing, automatic data exchange/report generation, doing business online, EBT, JIT, contracts process, invoicing, renewing licenses etc.	11
Workforce	Not Enough Staff	Workload increased but workforce size simply not large enough to do work in key areas.	8
Management	Need Emphasis on Operational/Process Mgmt	To enhance efficiency and effectiveness of programs and services, there is a need to improve operational processes and standardize functions.	7
Workforce	Lack of Qualified Candidates	There is a shortage of qualified candidates in specialized skill areas (such as RNs, psychiatrists, drug abuse counselors).	7
Information Technology	Need More Data Collaboration	Technical crosswalks not made (ex., DSS case across counties) - Data owners prohibit cross walk of data/information	7
Program-Service Delivery	Seamless Access for Customers	Programmatic applications serving citizens should be built around the recipient of services, not the programs delivering service.	6
Workforce	Insufficient Succession Planning	Insufficient planning for the retirement of leaders/managers.	6
Workforce	Need Increased Skills	Changes in program/service delivery and business environment have created a need for staff with more skills than current staff.	6
Information Technology	Access for Disabled	Information resources and tools need to be accessible to persons with disabilities (visual, hearing, intellectual, physical)	5
Information Technology	Legacy Systems	Existence of legacy systems creates a high risk of loss of support and difficulty enhancing and maintaining systems - the potential to fail to deliver services to the public.	5
Program-Service Delivery	Insufficient Funds to Meet Demands	Growth in demand for services surpasses available funding.	5
Management	Delays Due to State Processes	Initiatives are micro-managed, which results in significant delays or inability to carry out initiatives	5
Information Technology	Field Staff Tools and Access	Need better utilization of automation tools for gathering, analyzing and accessing data and information at the point of need/use.	4
Information Technology	Document Management	Document management to reduce storage space and secure critical vital records, improve processes, improve access to important documents, retention of records and tracking.	4

Business Functional Area	Issue Title	Issue Description	Responses
Information Technology	Lack Systems that Support Core Business	Systems required to support certain core business processes are lacking, sometimes resulting in substantial costs to the department.	4
Buildings and Facilities	Deteriorating Infrastructure	Many of the 900 buildings that NC DHHS occupies are old and outdated.	4
Information Technology	Need Enterprise Approach to IT Delivery	When applications are being developed whose functionality may benefit other divisions, need to assess as enterprise solution and involve all potential stakeholders.	4
Management	Contracts Process	Departmental contracts process not optimized for quick turn-around which inhibits effective enforcement of performance, creates long turnaround on IT contracts and is time consuming while adding little value.	4
Management	Lack of Cross-Organization Coordination	All impacted divisions not at table when initiatives/changes/issues being discussed.	4
Finance	Insufficient Operating Budget	Funds are not allocated on a recurring basis to cover basic operating expenses - that increase annually due to inflation and growth.	4
Workforce	Need for Employees with Multiple Languages	Staff are needed that can speak languages other than English - cultural competencies.	4
Program-Service Delivery	Real-Time Access to Patient Information	Need single electronic medical record for patients.	4
Program-Service Delivery	Use of Geographic Information System	Desire to further utilize GIS to more effectively deliver programs and services.	4
Information Technology	Video Conferencing	Desire to utilize video conferencing to communicate with staff and stakeholders across state for meetings and training.	3
Finance	Real Funding Inflexibility	Restrictions in funding inhibit department/divisions from delivering programs and services in the best way.	3
Program-Service Delivery	Need Controlled Substance Database	Need a database for tracking patient usage of controlled substances.	3
Workforce	Lack of Flexibility in Job Classifications	Managers are not able to create job classifications that they feel best suit their workforce needs, either because of funding limitations or OSP restrictions.	3
Information Technology	Not All Employees Have Access to Electronic Info	Not all staff have access to a computer. This poses difficulties in using IT to deliver information and enabling employees to manage their information.	2
Buildings and Facilities	Spread Out Workforce	Personnel performing similar functions or needing regular access to others in the department are not optimally co-located.	2
Finance	Inflexible Use of Funding Sources	Reluctance to blend funding to accomplish goals or modify program/service delivery because of actual or perceived limitations in funding stream that does not actually prohibit such usage.	2
Finance	Lack of Sustainability of Funding	Divisions often pursue or are encouraged to pursue grants that require the state to fund the effort after the initial pilot.	2
Information Technology	Ad Hoc Management Analysis of Data	Management needs the ability to access existing data for ad hoc analysis.	2
Information Technology	Desktop Mgmt	Unified approach to desktop/LAN management	2
Workforce	State Cannot Compete with County Compensation	Counties offer better compensation for similar positions which makes it difficult for the state to recruit and retain.	2

Business Functional Area	Issue Title	Issue Description	Responses
Workforce	Insufficient Training	Training available for state workforce is insufficient, either resulting in reliance on contractors, under-qualified staff, or loss of staff.	2
Information Technology	Need Business Partnering with IT	Approach of customer service is to give specific customer exactly what they want rather than a consultant model of business partner and an enterprise approach.	2
Program-Service Delivery	Legacy Systems Prevent Service Changes	Managers of programs are frequently unable to make modifications to existing legacy systems necessary to enable improvements.	2
Information Technology	EA Concern	Concerned that specific needs will be lost in enterprise approach to IT solutions	2
Buildings and Facilities	Problems with Leases	Delays experienced in resolving issues with leased property.	1
Management	Proactive Management	Anticipate need to request management information to allow divisions plenty of time to respond to requests.	1
Communications	Feedback	Desire effective feedback mechanisms, formal and informal, internal and external.	1
Communications	Need to Effectively Market Prog/Services	In some instances, the intended beneficiaries of programs and services do not know they exist.	1
Communications	Use Data Better in Communications	Need to be able to present data in formats that can more clearly communicate to constituents.	1
Program-Service Delivery	High Fuel Costs	High cost of fuel affecting program/service delivery	1
Workforce	OSP Value Operational/Mgmt Skill	The current job classification system does not value business, finance, quality and process improvement skills.	1
Information Technology	All Offices for Div not on same Network	The offices for a division are not all on the same network.	1
Program-Service Delivery	Improve Prog/Serv Delivery Through use of Tech	Many opportunities exist for improving program and service delivery with effective utilization of technology i.e., tele-medicine; electronic health records, etc.	1
Finance	Shift of Funding Burden to State	Changes in federal programs are resulting in shifts of funding burden to states.	1
Information Technology	Access to Information for External Partners	Need the ability to provide restricted access to documents and information to defined external partners.	1
Information Technology	Security	Concern that digitized information is vulnerable to hackers accessing it or modifying it.	1
Workforce	Inflexible Employment Rules	Inflexibility in the state's employment laws makes it difficult to implement creative solutions to HR problems	1
Management	Need Just In Time	The department could save space and money by using just in time inventory processes.	1
Finance	Insufficient Reimbursement Rates	The reimbursement rates for Medicaid eligible services are significantly below the cost of providing those services.	1

Summary of Operational Issues

Most Frequently Mentioned Operational Issues for Programmatic Agencies

Business Functional Area	Issue Title
Workforce	Inability to Attract & Retain Qualified Workforce
Information Technology	Insufficient Automation of Manual Processes
Program-Service Delivery	Seamless Access for Customers
Workforce	Insufficient Succession Planning
Workforce	Lack of Qualified Candidates
Information Technology	Need More Data Collaboration
Information Technology	Access for Disabled
Management	Need Emphasis on Operational/Process Mgmt
Program-Service Delivery	Insufficient Funds to Meet Demands

Most Frequently Mentioned Operational Issues for Support Agencies

Business Functional Area	Issue Title
Workforce	Inability to Attract & Retain Qualified Workforce
Information Technology	Insufficient Automation of Manual Processes
Workforce	Not Enough Staff
Workforce	Need Increased Skills
Finance	Insufficient Operating Budget
Management	Delays Due to State Processes
Buildings and Facilities	Spread Out Workforce
Workforce	Insufficient Training
Management	Need Emphasis on Operational/Process Mgmt

Appendix 4

Demographic Influences from Business Plan Questionnaire

Summary by Programmatic Agencies
(CDD, DAAS, DCD, DFS, DMA, DMH/DD/SAS, DPH, DSB, DSDHH, DSS, DVR, OEO, OES, OMHDD, ORHCC)

SUMMARY			
Group	**Trend**	**# Hits**	**Rank**
A	Aging Population	14	1
C	Immigration issues, especially Hispanics who don't speak English	13	2
B	Growth of eligible populations (Aged, Children, Disabled, Poor, etc)	10	3
F	Budget shortfalls / issues	10	3
L	Unemployment / layoffs / plant closings	7	5
E	Cost of care / services increasing	6	6
D	Individuals / families in poverty or minimum wage	5	7
Q	Decrease in providers / unavailability of providers or services	5	7
U	Decrease in rural industries / movement from rural to urban	4	9
G	Natural disasters	3	10
H	Technology advances, including medical technologies	3	10
K	Increase / transition to community services	3	10
M	Multiple disabilities / conditions	3	10
P	Aging Workforce	3	10
S	Aging Facilities / Equipment	3	10
T	Recruitment issues / shortages of nurses and other professions	3	10
I	Rise / Fall in Economy	2	17
R	Federal teaching requirements	2	17
V	Job market skills changing	2	17
W	Growth in uninsured	2	17
X	Increasing HS drop out rates	2	17
J	Increase in single parent families	1	22
N	Unfunded mandates	1	22
O	Obesity and associated health risks	1	22

Division	Demographic Issue	Group
CDD		
	None Enunciated	
DAAS		
	Aging population	**A**
DCD		
	An increase in the number and/or proportion of children and/or overall population of NC	**B**
	A probable increase in NC's Hispanic population	**C**
	The overall aging of NC's population	**A**
	Changes in parents' wages/employment status	**D**
	A possible increase in the state minimum wage will make a difference to low-income parents	**D**
	The cost of care is expected to increase	**E**
	Changes in State/Federal budgets	**F**
	Increasing numbers of serious natural disasters/events	**G**
	Advances in medical technology as well as social/environmental changes	**H**
DFS		
	Changes in reimbursement policies by payors that affect access to care	**E**
	Shifts in population over 65 (>in Assisted living and Home care)	**A**
	Market conditions up or down	**I**
	Flat lined or decreased Medicare and/or Medicaid funding to Agency.	**F**
	Natural or man made disasters affecting health care delivery	**G**
	Increases in jail population	**J**
	Deinstitutionalization of mental health services into community settings	**K**
DMA		
	Downward or upward change in the national, state or local economy	**I**
	Rising cost of health care and malpractice insurance	**E**
	Major industry closings & layoffs	**L**
	Natural disasters	**G**
	The natural aging of our existing population	**A**
	In-migration of retirees to our State	**A**
	Growing number of non-citizens and seasonal/migrant workers	**C**
	Federal trends threaten to increase the financial burden of each State	**F**

DMH/DD/SAS		
	A strong consumer voice that continues to grow and drive state policy.	K
	Increased diversity among consumers indicates need for more linguistic and culturally competent staff.	C
	Potential decreases in domestic funding at the federal level from such programs as Medicaid, block grants, housing and employment.	F
	Limitations in funding of community services for MHDDSAS creating increasing demand for inpatient and institution based services.	F
	Downsizing of state facilities and budget reductions.	F
	Adjusting to how LMEs use the new formula for allocating bed days for individual patients.	E
	Increase in unfunded regulatory mandates. Examples - HIPAA Privacy, HIPAA Security, OSHA, CMS, Federal Inpatient Prospective Payment System (IPPS), etc.	N
	Absence of planned budgetary increases based on population growth and inflationary increases, especially at the community level.	F
	Rise in the North Carolina population, including growing elderly and Hispanic populations.	A B C
	Psychiatric hospitals' admission rate and census are affected by population increases, unemployment levels, community capacity, and prevalence of substance abuse.	BL
	Need to develop programming, linguistic and cultural competencies to address the growing Latino, Asian, aging, and homeless populations.	C
	Increased influx of children with autism and other developmental disabilities at state facilities.	B
	Trend for state facilities to serve individuals with most extreme needs (medical and/or behavioral) and an aging population within facilities.	P
	Increasingly large numbers of individuals with severe and profound developmental disabilities and cognitive impairment who are living longer and more normalized lives.	B
	Poly-substance dependence is now the norm, rather than the exception, among a larger cross-section of the population who often end up with financial, mental and physical complications.	M
	Increased numbers of people affected by Alzheimer's Disease (doubled since 1980), aging with developmental disabilities and the increased risk for Alzheimer's Disease among people with Down Syndrome. A percentage of those affected in North Carolina will have significant medical and behavioral support needs that can only be met in a specialized setting and nursing care facilities.	A M
	Limited resources in community for placement of psychiatric rehabilitation of patients.	Q
	Un-served and underserved populations and the lack of services being provided in the community setting.	Q
	LMEs have had difficultly developing community capacity in rural areas.	Q
	The state of and availability of the workforce in NC that is shifting from traditional manufacturing and possibly to human services.	U

DMH		
	An aging workforce at state facilities that impacts the staff's ability to perform physical requirements for their positions (i.e., NCI restraint and seclusion).	**P**
	Major loss of jobs in the furniture/manufacturing industry that potentially provides a larger pool of mature and stable applicants for support services (such as dietary and housekeeping) and direct care.	**L**
	Demand for staff with interpreting skills (Hispanic and Asian).	**C**
	Significant increase in retirees and elderly that increases the demand for health care services (including PT, OT, and speech) at state facilities.	**A**
	Inability of state to offer competitive salaries in relation to the local labor market.	**T**
	A nursing shortage continues to exist along with a highly competitive job market, which impacts ability to recruit/retain quality nursing staff.	**T**
	The aging of and need to replace state facilities.	**S**
	Aging equipment, lack of funding for preventative maintenance, and the need for improvements related to technology hampers productivity and patient care.	**S**
	Rapid advancement in information technology and information systems;	**H**
DPH		
	Population growth	**B**
	Increasing cultural diversity and language issues (Latino, Hmong and Russian growth)	**C**
	Aging population.	**A**
	Economic factors include downward trends in the economy, increases in poverty (NC has 5th fastest growth rate), and increasing numbers of uninsured citizens (17.5% in 2004).	**D**
	North Carolina has a high drop out rate, particularly for African American males.	**X**
	Increasingly, efforts addressing the prevention and control of many chronic disease conditions will focus around alarming increases in obesity and the associated health risks.	**O**
	Core public health funding at the federal level is being reduced. Budget cuts will result in loss of service capacity.	**F**
	Public health's work force is beginning to reach retirement eligibility, which will result in a significant loss of institutional knowledge and experience.	**P**
DSB		
	Increase in aging population and retirees in NC	**A**
	Growth of NC population, people moving here from other states, as well as foreign immigrants	**B C**
	Advances in medical treatment	**H**
	NC moving from a primarily agricultural state to service and technology	**U**
	Increase in rural planning and population	**B**
	A broader awareness of people with disabilities working in a wide array of career fields	**V**
DSDHH		
	Aging population. NC residents with hearing loss will more than double by 2030.	**A**
	Hearing loss is compounded by depression and anxiety and needs are growing in this area.	**M**

DSS		
	Increased poverty	**D**
	An increase in children who have difficulty speaking English / Immigration issues	**C**
	Unemployment	**L**
	High School Dropouts	**X**
	An increase in single parent families	**J**
	Lack of / losing community based MH services, SA programs, and other supportive services	**Q**
	Population growth, especially children	**B**
DVR		
	People with disabilities are an increasingly larger % of the population	**A**
	Significant increases in the Latino and Asian populations in NC	**C**
	Persons with significant disabilities are substantially under-represented in the workforce and unemployment for persons with disabilities remains disproportionately high.	**L**
	Forty-one million Americans are without health insurance. Those still insured are faced with demands for increased cost sharing and limits on health care coverage.	**W**
	Workers are staying in the job market longer.	**A**
	As the baby boomers continue to age, the prevalence of disability in the workplace will continue to rise.	**AB**
	Skills needed to remain competitive in the job market continue to change.	**V**
OEO		
	Population trends such as the movement of low-income families from rural to urban communities	**U**
	Employment trends such as the increase in dislocated workers due to the loss of manufacturing jobs	**L**
	Economic trends such as the rising costs of fuel	**E**
	National downward budget trends in funding for the programs and services overseen	**F**
OES		
	Growth in the Spanish speaking population across NC	**C**
	Federal and state requirements for Highly Qualified Teachers (No Child Left Behind, IDEIA)	**R**
	Recruitment: the increasing need for teachers as more retire and fewer are trained	**T**
	Medical advances, particularly those related to the survival rates of premature babies and new advances in medical treatment of hearing and vision loss	**H**
	Rising cost of transporting students, especially at the residential schools	**E**
	IHE programs for training teachers for low incidence population are experiencing stress in their systems	**R**
	Operating in old, outdated building in need of many repairs	**S**

OMHHD		
	Increase in Latino and other minority/immigrant populations	**C**
	Increase in percentage of people living in poverty	**D**
	Increase in number of Community Based Organizations and Faith based Organizations	**K**
ORHCC		
	Immigration, multilingual issues	**C**
	Aging population	**A**
	Population growth	**B**
	Growth in uninsured	**W**
	Decrease in industry in rural areas	**U**
	Unemployment	**L**
	Decrease in primary medical care providers	**Q**
	Federal budget deficit	**F**

Demographic Influences from Business Plan Questionnaire

Summary by Support Agencies
(B&A, DIRM, HR, OCS, OIA, OOC, OPA, OPC, OPCS, OPP)

SUMMARY			
Group	**Trend**	**# Hits**	**Rank**
C	Budget cuts, budget deficits, not enough money being spent	7	1
D	Unemployment, growth in uninsured, increase in poverty, plant shutdowns, job loss	5	2
E	Aging of the workforce, increased retirements from workforce	5	2
F	Impact of federal and state regulations on technology, programs and service delivery	5	2
G	Technology advances impacting program and service delivery, need for technology	5	2
B	Immigration	4	6
A	Population Growth	2	7
H	Recruitment difficulties due to increased need for certain occupations and shortages	2	7
L	Rising cost of transporting students, rising fuel costs	2	7
I	Shortage of resources (people, tools) to effect culture change in service delivery	1	10
J	High growth occupations in NC DHHS will create shortages	1	10
K	Trend toward performance based management	1	10
L	Uncertainty of office status	1	10
M	Demand for healthcare services is increasing	1	10
N	Public Health Issues	1	10
0	Outsourcing	1	10
Q	Other economic factors … high growth occupations impact to HHS employment	1	10

OFFICE	DEMOGRAPHIC TRENDS	Group
B&A		
	The effect of economic trends that influence the ability of the state to collect tax revenues has a considerable impact upon division operations. A recessional or static economy reduces the ability of the state to collect additional tax receipts. Inflationary pressure and an expansion in demands for services (often prompted by a recessional economy) creates demand for additional revenue. The net effect is the need to constrain program growth in some areas and reduce program size and scope in other areas. The budgetary impact of these influences creates a substantial burden on work load and a commensurate change in working relations with divisional budget and program offices.	**C**
	Changes in the availability of state appropriations or federal receipts. (e.g., block grant legislation, reduction or expansion items in appropriations bills, etc.) that will require modifications in the operating budget.	**C**
	Changes in federal regulations, APA rules, or special provisions contained in appropriations bills that impact program operations.	**F**
	Population increases as they impact Department services.	**A**
	Public Health issues (Avian flu, mad cow disease, HIV/AIDS, etc.).	**N**
	Redirection of Federal services to the States without sufficient funding or support.	**C**
	The introduction of new programs without adequate funding.	**C**
DIRM		
	Based on recent and anticipated state and federal legislation that affect technology (ex.: HIPAA, Identity Theft), DIRM will be required to alter its service delivery approach.	**F**
	Recent legislation at the state level (ex.: Senate Bill 991, IT Consolidation) will affect how DIRM delivers and manages technology solutions. The department will need to focus on the delivery of services at the enterprise level, maintaining a holistic view to improve our services to our customers and to reduce duplication of service delivery.	**F**
	DIRM will channel efforts toward single entry and access to our services for our customers by providing automation where appropriate and eliminating stovepipe solutions.	**G**
	Recent population trends in North Carolina indicate that DIRM will need to increase its focus in the delivery of multilingual services to meet the needs of our citizens.	**B**
	DIRM will continue to face the complexities of an aging workforce and its effect on delivery of technology solutions to the divisions and offices within NC DHHS.	**E G**
	Increasing focus on information security will continue to affect our service delivery approach in all areas of information technology.	**G**

HR		
	Aging of the workforce	**E**
	Demand and supply of certain occupational groups, such as nursing, and increasing licensing requirements for some professional jobs usually reduces the labor supply, increases wages and makes recruitment more difficult.	**H**
	Other economic factors include DOL projections that health care, medical care, allied health and IT are projected to be high growth occupations which has a direct effect on HHS employment.	**J**
	The absence of competitive funding for compensation programs (salary and benefits) by the legislature will see a continued erosion of state salaries and benefits compared to competitors.	**C**
	HR lacks resources to achieve its goal to shift to provide consultation on organizational development, enhance education offerings, and develop other initiatives.	**I**
OCS		
	Population growth, especially retirements and Hispanic / Latino	**A B E**
	Many programmatic changes such as Medicare-D, Mental Health Reform, Medicaid cuts, refugee services	**F**
	Plant shut downs and layoffs	**D**
OIA		
	None	
OOC		
	Non-Competitive pay of state workers compared to other sectors of the economy	**C**
OPA		
	More reliance on the Internet, email and web for information delivery.	**G**
OPC		
	Economic trends, particularly inflation in labor and material costs.	**C**
OPCS		
	High percentage of workforce near or at retirement eligibility	**E**
	Demand for healthcare services is increasing	**M**
	Outsourcing reduces internal competencies	**O**
	Technology - process automation	**G**
OPP		
	Trend toward performance based management and the importance of measuring outcomes	**K**
	Uncertainty of office status	**L**
	State wages not competitive with other sectors of the economy	**C**

Appendix 5

SWOT Analysis

Management Vision and Control

Strengths	Weaknesses
• Recognized strong leadership from the secretary • Very strong programmatic leadership in agencies • Adoption of performance based management concepts, expectations and practices • Good regulatory and financial compliance infrastructure	• Leadership is vulnerable due to lack of succession planning and potential "brain drain" • Lack of focus on operations • Reactive vs. proactive management focus • Manual process inefficiencies • Much responsibility with little authority • Layered internal and external oversight and review • Too much emphasis on activity instead of value added and outcomes • Federal dollars are pursued even when state matching funds cannot be sustained over time • Inefficient disbursement of staff in multiple locations
Opportunities	**Threats**

• Establish culture of continuous improvement
• Increase programmatic coordination
• Development and utilization of better management tools
  o Program Management Database (PMD)
  o Integration of PMD, Contracts and Monitoring systems
  o Integration of PMD with budget processes
  o Grants coordination
• Increase emphasis on management operational skills as a means to enhance program effectiveness and operational efficiencies
• Establish routine succession planning
• Expand LeadershipDHHS to identify and train future leadership
• Becoming more proactive (i.e., focusing on prevention, disaster planning, cost containment, etc.)
	• Limited resources to compensate management talent
	• Restricted management authority due to internal and external review
	• Cyclical changes in upper management can lead to:
	  o Loss of continued support for positive/effective initiatives
	  o Re-education and delays (exec staff)
	  o Management void (at beginning and end of administration)
	• Limits on ability to easily use various data sources for management decisions making

Departmental Information Technology

Strengths	Weaknesses
• Department has a wealth of data available • IT has been deemed critical to business processes and program success • Systems that support federal reporting requirements are available • IT supports accessibility requirements for persons with disabilities • Renewed commitment to customer service	• Inconsistent data standards complicates information sharing • Inability to optimally use electronic data to support executive decisions • Obstructions to taking an enterprise approach to IT, such as redundant and/or duplicative processes and data repositories • Inability to respond quickly to changes due to outmoded equipment and systems
Opportunities	**Threats**
• Shifting focus to IT consolidation and common shared technical infrastructure and technical services • Innovations toward remote computing • Renewed State interest in electronic document management • Federal and local partnerships and support to consolidate common systems (ex. HIS and NC FAST)	• Unforeseen Federal and State mandates that may impact IT • Turnover of knowledgeable IT workforce before transition to new modern environment takes place • Volatile funding support for IT salaries, training, and infrastructure needs

Workforce

Strengths	Weaknesses

• Experienced workforce
• Strong program expertise
• Commitment to serve public
	• Weak operational leadership
	  o Process analysis
	  o Lack of operational skills and particular expertise
	  o Don't have analytical skills to best use data
	• Inability to recruit, retain, and reward highly qualified personnel
	• Reluctance to dismiss non-performers due to outdated and cumbersome HR/OSP processes
	• Aging workforce retiring
	• Lack of enterprise approach to HR – management by exceptions instead
	• Tendency toward acceptance of status quo rather than pushing for change
	• Emphasis on equity results in inequity

Opportunities	**Threats**

• Redefine workforce needs through a department wide succession plan
• Implement prompt human capital changes
  o Hiring
  o Transfers
  o Increases
  o Reclassifications
• Implementation of HRIS
• LeadershipDHHS
• Succession planning for the department
	• Lack of availability in market of certain skill sets
	• Inability to do personal services contracts for particular expertise/skills
	• Imposed qualifications from fund sources (fund restrictions) NOT CLEAR
	• External review and control over workforce decisions
	• Classification system doesn't value operational/management skills
	• Accelerating retirements due to aging workforce creating management voids

Program & Service Delivery

Strengths	Weaknesses
• Scope of services available to populations served • New emphasis on prevention • Adoption of evidence based practices, cost containment and avoidance, emphasis on prevention, consumer choice and other initiatives • Implementation of performance management practices • Better management of service delivery via performance based contracting initiatives • Wider sharing of program and service information via the Program Management Database (PMD)	• Available services do not always reach all possible intended beneficiaries • Cost containment efforts offset by program growth • Services for same intended beneficiaries reside in multiple divisions • Difficult to collect accurate race information
Opportunities	**Threats**
• Electronic delivery of programs and services. Examples: o Tele-medicine o Case management o Document management o E-health records o Better utilization of Geographic Information System (GIS) technology o Improvements in assistive technologies • Better Outreach/Marketing of programs and services • Data sharing on clients may lead to better coordination and efficiency on programs/services (NC Fast) • Program Review process may lead to improved program and service design and delivery and better outcomes	• Regulatory requirements limit flexibility in program design • Projected program growth not accompanied by increased revenues or human resources

Budget and Finance

Strengths	Weaknesses
• Track funds accurately according to codes, standards, and accounts • Good financial controls • Ensure compliance with funding requirements	• Perceived inflexibility of how funding can be used • Lack of financial analytical skills makes cost containment and financial analysis difficult • Lack of transparency in financial information (due to outdated state budget structure and system) makes it very difficult to determine where money is going and for what purpose • Lack of sufficient staff—particularly in the Office of the Internal Auditor—to operate in proactive mode
Opportunities	**Threats**
• Results based budgeting • Clarify restrictions of funding flexibility • Linking financial/budgeting reporting requirements to the PMD	• External agencies make decisions on limited information because of lack of transparency in financial information • State does not utilize an inflationary factor to cover standard operating costs (such as for utilities, IT maintenance, growth in facility populations, etc.)

Communications

Strengths	Weaknesses

• Strong community networks, for example:
  o CCNC
  o County partners (health depts., social services, etc.)
  o LMEs
  o Other regional offices
• CARE-line
• Emergency response network and emergency operations center
• Availability of enterprise calendar and e-mail is nearly universal
	• Inability or unwillingness to share information
	  o Lack of standards of usage of information tools (i.e., calendar and e-mail)
	  o Often ineffective internal communications
	• Good works often go unnoticed
	• Some staff within NC DHHS do not have access to electronic communications
	• Websites not user friendly
	• Failure to utilize complaint information to improve problem areas
	• Don't use all communications channels available (pod casting, infomercials, videoconferencing)

Opportunities	**Threats**

• Clarify roles and responsibilities around types of communications, i.e.:
  o Marketing/Outreach
  o Public Relations
  o Internal Communications
• Be more proactive in shaping our public image
• Use CARE-LINE data and other complaint desk information for early detection analysis, complaint resolution and process improvement
• Website redesign
• Kiosks for NC DHHS staff who do not have access to computers
	• Perceived image—in the public, General Assembly and other stakeholders and partners
	• Failure to identify ways to improve internal communications

Buildings & Facilities

Strengths	Weaknesses
• Recognized strong facilities management expertise • Statewide locations which facilitate consumers' access	• Scope of renovations and repairs required to support existing infrastructure exceeds state's funding • Crowded locations • Inefficient disbursement of staff • Old buildings: o Out of date designs do not support today's operations o Environmental quality issues o Aesthetically challenged
Opportunities	**Threats**
• Construct new, state-of-the-art hospital(s) • Opportunity for new, more centralized NC DHHS office building depending on disposition of Dix campus • New state lab and medical examiner facility	• Vital records and other records inappropriately stored and security/safety jeopardized • Layered oversight and review o Funding dictated to project level o Minor changes in spending plan for COPs requires review by numerous state agencies o State process for leases not optimal